

RUC Five Year Review
Recommendations

Volume 1

1995

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE YEAR REVIEW OF THE RBRVS
RECOMMENDATIONS

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American Medical Association

Physicians dedicated to the health of America



Grant V. Rodkey, MD
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September 28, 1995

Mr. Thomas A. Ault
Director, Bureau of Policy Development
Health Care Financing Administration
7500 Security Boulevard, C5-01-17
Baltimore, MD 21244

Dear Mr. Ault:

I am pleased to provide you with the recommendations of the American Medical Association/Specialty Society RVS Update Committee (RUC) for the five-year review of Medicare's resource-based relative value scale (RBRVS). Although the five-year review presented an unprecedented opportunity to improve the accuracy of the physician work component, it also presented a significant challenge to the medical community. The enclosed recommendations reflect evaluation of the work involved in services of every type and those which are provided by virtually every medical specialty, as well as many of the other health professions.

Upon completion of your review, I believe you will agree with me that the RUC has successfully met this challenge. We have held all of the proposed changes in work values to a very high standard of proof, and refrained from recommending increases in values unless a compelling argument was presented. Likewise, we have required specialties to present a compelling argument in order to maintain the current values of services that were identified in comments as being overvalued. Despite the limited number of RUC-recommended changes in values as compared to the number of changes proposed in the comments, assuming that all of the RUC's recommendations are accepted, we believe that the physician work component of the RBRVS as a whole will be significantly more accurate and correct than it is currently. By relying on the RUC for assistance in the five-year review, the Health Care Financing Administration (HCFA) has ensured that the clinical experiences of practicing physicians will be reflected in any changes that are made. As you know, the widespread adoption of the Medicare RBRVS by other third-party payors underscores the need for it to be as accurate as possible in reflecting the realities of clinical practice.

Scope of the Review

During the public comment period from December 8, 1994 until February 6, 1995, HCFA received about 500 comment letters identifying about 1,100 CPT codes for review. Three specialty societies submitted RBRVS studies conducted for them by Abt Associates Inc., which spanned all of the more than 2,000 codes used by physicians in those specialties. The carrier medical directors' review identified about 900 codes. The American Academy of Pediatrics (AAP) submitted comments claiming that the physician work involved in providing 480 services to pediatric patients is different than when these same services are provided to adult patients. After preliminary screening, HCFA referred to the RUC:

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- public comments on 669 codes;
- carrier medical director (CMD) comments on 387 codes;
- the three special studies by Abt Associates Inc.; and,
- the comments submitted by the American Academy of Pediatrics.

Eliminating some overlap (e.g., both the American Society of Anesthesiologists and the AAP commented on all of the approximately 250 anesthesia codes), the total number of codes referred to the RUC in late February was about 3,500. The entire RBRVS was considered by the profession, but, through their exclusion from the comments submitted, we may infer that the remainder of the codes were felt to have been appropriately ranked.

Review of Abt Studies

The RUC employed a process similar to its annual update process to evaluate the public and CMD comments. This method is further detailed below. The RUC referred the three Abt studies to the Research Subcommittee to evaluate the methodologies used before considering the actual recommended work values. The Research Subcommittee concluded, and the RUC agreed, that the Abt studies for orthopaedics and otolaryngology produced correct rank ordering of codes within the respective specialties, but that additional study would need to be conducted to constitute compelling evidence that the proposed relative values were correct. The Research Subcommittee did not reach any conclusions about the ASA Abt study, but indicated that the specialty was not precluded from demonstrating the validity of its methodology through the workgroup process.

Following this methodological review, the American Academy of Orthopaedic Surgeons (AAOS), with HCFA's concurrence, withdrew its Abt study from consideration and developed a list of 83 codes for which it conducted a survey using standard RUC methodology and submitted individual recommendations on them to the RUC. The American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) had already provided detailed comments on about 100 codes to HCFA in addition to submitting its Abt study. The AAO-HNS did not present further validation of its Abt study to the RUC, but evaluated the work of the individually identified codes and made recommendations to the RUC. The ASA conducted further research to validate its Abt study and presented the results to a RUC workgroup and to the full committee.

Pediatric Comments

The comments submitted by the AAP responded to HCFA's question of whether the work involved in treating pediatric patients is different than adult patients. The AAP requested that new codes be added to CPT to describe different age categories of patients, and that relative values be assigned to these codes reflecting the differences in work for patients of different ages.

To consider the AAP comments, the RUC formed a new subcommittee comprised of RUC members and several members of the CPT Editorial Panel. This committee provided guidance to the AAP to refine its proposal and reduce the number of new codes that would need to be added.

The recommendations for this group of comments are expected to be included in the RUC's recommendations for new and revised codes for CPT 1997.

Review of Public and CMD Comments

The RUC's process for evaluating codes included in the five-year review involves the same basic methodology as the annual update process, with some important innovations. First, a modified survey instrument was developed (see Attachment 1). Because the five-year review involves evaluating the work of established codes with established RVUs, "compelling arguments" were needed to support changes. To help gather evidence to support such arguments, in addition to comparing the total work involved in the services under review to key reference services, survey respondents were asked to provide a detailed comparison of the pre-, intra-, and postservice time involved in the key reference services selected. For surgical procedures, postservice time was further divided for this purpose into time on the day of the procedure, time in the intensive care unit, hospital visits, and office or other outpatient visits following discharge.

Questions were also added regarding the other elements of work besides time and the extent to which the service has changed over the last five years. The nontemporal components of work are the physician's mental effort and judgement, technical skill and physical effort, and stress due to the risk of mortality or iatrogenic harm to the patient. Respondents were asked to rate the complexity of each of these components for the services under review and key reference services. If they believe the service has changed over the past five years, they were asked whether: the service represents new technology that has become more familiar; patients requiring the service are more or less complex; and, if the usual site of service has changed.

Visit and consultation codes. The codes addressed by the public comments included many of the CPT codes for evaluation and management services. Since the new codes for these services were introduced simultaneously with the RBRVS in 1992 and they have not been revised during the annual update process, their inclusion in the five-year review presents the first opportunity for the RUC to evaluate their relative physician work. In the public comment letters addressing these services, the major primary care specialty societies stated that the services had become more difficult than they were when the Harvard RBRVS surveys were conducted, due to factors such as decreasing lengths of stay, increasing complexity of patients in inpatient and outpatient settings, documentation and case management requirements, and a better educated patient population that expects more information from physicians. The modified survey instrument was further modified, therefore, to make it more appropriate for surveying the work involved in visits and consultations and addressing the issues raised in the primary care groups' comments.

Multidisciplinary workgroups. In addition to the survey instrument, modifications were also made in the RUC review process. For example, to manage the large number of comments referred and to ensure objective review of potentially overvalued services, the RUC adapted the facilitation committee concept used in valuing new and revised codes to the five-year review. Prior to reviewing the comments, therefore, the RUC members were divided into eight multidisciplinary workgroups of three or four members, each comprised of at least one surgeon, one

primary care physician, and one from another medical specialty, such as radiology (see Attachment 2). The public and CMD comments were then organized into 21 topic areas, and several topics were assigned to each workgroup. The workgroups were responsible for providing assistance to specialties upon request, for example, by reviewing proposed vignettes. After the specialty recommendations were provided to the RUC, the workgroups evaluated the recommendations for the topics assigned to them and made recommendations to the RUC. These recommendations were treated as consent calendars by the full RUC, with other RUC members and specialty societies extracting for discussion any workgroup recommendations with which they disagreed.

Supplemental data. Another innovation was the collection of information besides that which was developed by the specialty societies to facilitate evaluation of the comments. In addition to the specialty recommendation forms, therefore, the AMA assembled data from several sources into a supplemental report on each code, which was provided to the workgroup members and the full RUC (see Attachment 3). First, the tables provided by HCFA summarizing all the public and CMD comments included: 1995 RVUs and their source; the commenter's recommended RVUs; the ratio of the recommended to the 1995 RVUs; the frequency of claims for the service; and, the reference services identified by the commenter. Second, an AMA analysis of Medicare claims data for each service provided: beneficiary age and other characteristics; recent trends in claims frequency and site of service; specialties that provide the service; and, diagnosis codes reported on claims. Third, each code was analyzed to assess any changes in RVUs during the first four years of RBRVS implementation, and how the 1995 Medicare RVUs compare to the final RVUs from Phase III of the Harvard RBRVS study. Finally, all the available data from the Harvard study was assembled for each code, including pre-, intra-, and postservice times, number and type of postservice visits, and the ratio of intraservice work to intraservice time.

Additional Potentially Overvalued Services

As described in Tab 19, in addition to reviewing the referred comments, the RUC also conducted a special analysis to identify additional potentially overvalued services that were not identified in the public or CMD comments. The RUC's evaluation of several of the 33 services so identified has not yet been completed, but, at this time, the RUC is recommending that the relative values for one third of these services be reduced.

Summary of Recommendations

Tabs 1 through 18 present the RUC's recommendations on the comments referred to us, grouped into the topic areas discussed above and listed in Attachment 2. In addition, Tab 19 discusses the 33 additional potentially overvalued services identified by the RUC, and Tab 20 explains those codes that the RUC recommends be considered by the CPT Editorial Panel prior to any further review of their relative values by the RUC. The RUC's recommendations may be summarized as follows:

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- For 158 codes, the RUC is recommending that the increase proposed by the specialty society or CMD be adopted.
- For 138 codes, the RUC is recommending that the relative value be increased, but by less than the specialty has recommended.
- For 650 codes, the RUC recommends that the current relative value be maintained. The RUC also recommends the current relative values for the anesthesia codes be maintained.
- For 101 codes, the RUC is recommending that the decrease proposed by the specialty society or CMD be accepted.
- For 6 codes, the RUC has developed a recommended decrease to maintain work neutrality with closely related codes.
- The RUC has referred 65 codes to the CPT Editorial Panel to consider coding changes prior to further review by the RUC.

Excluding the issues referred to CPT, the total number of recommendations being submitted at this time is 1,053. All of these recommendations are discussed and explained in the reports contained in each tab. In addition, for codes for which the RUC is recommending an increase and codes for which the commenter recommended a decrease but the RUC is recommending that the current RVUs be maintained, we have included the "summary of recommendation" form provided by the specialty society and the two-page data report containing the Harvard study and Medicare claims data discussed above. Please note that, in most cases, the specialty recommendation forms indicate the increase recommended by the specialty to the RUC, but in many cases the RUC-recommended relative values are lower.

Throughout the review process, the AMA has used the claims data provided by HCFA to assess the impact of the comments and the recommendations. The final RUC-recommended values are a fraction of what was proposed in the comments, particularly considering that many of the comments for high volume services did not specify recommended relative value units. Nevertheless, the overall impact of adopting the RUC's recommendations will be significant. More than 90% of the overall impact is due to the recommended increases in the evaluation and management services, since these services account for about 35% of all Medicare expenditures on the payment schedule, far more than any of the other families of services considered in this five-year review.

We appreciate the opportunity to assist you in this review process and HCFA's confidence in our ability to do so. I have selected several RUC members to attend the November meetings when the CMDs will review the RUC's recommendations to answer further questions that may arise.

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We strongly encourage HCFA's adoption of all of these recommendations. Please contact Sandra Sherman at the AMA if you have any questions about the enclosed materials.

Sincerely,



Grant V. Rodkey, MD

Encl.

cc: James S. Todd, MD

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS

IMPORTANT: PLEASE READ THE INSTRUCTIONS BEFORE COMPLETING THE QUESTIONNAIRE

Step 1: Please evaluate the physician work for each service described on the attached questionnaire. Please consider all of the following before providing your estimate:

Definition of Physician Work: Physician work includes four components: (1) the time it takes to perform the service, (2) mental effort and judgement, (3) technical skill and physical effort, and (4) stress associated with the physician's concern about iatrogenic risk. See Appendix A for further details regarding the components of physician work for the services you are rating.

Typical Patient/Service: Your specialty has developed a short description or "vignette" describing the typical patient/service for each service you will be evaluating. Base your estimate on this typical patient/service. Do not allow your rating to be influenced by unusual or atypical patients.

Reference Services: Compare the service described on each questionnaire to the reference services listed in Table 1. For example, if the service involves the same amount of work as a reference service, assign the same work value to the code you are rating. If the service involves twice as much work as the closest reference service, you would assign a work value that was twice that of the reference service value. If you think that the service involves half as much work as the reference service, you would assign a work value that was equal to half the reference service value. These services have been selected by your specialty for use as reference services for this survey because the services and their relative values are sufficiently accurate and stable to compare with other services. Do not change the work relative values (RVUs) for any of the reference services.

Global Period: A service paid on a global basis includes visits and other services provided in addition to the basic procedure during the day preceding the procedure and for a specified number of days after the procedure is provided. The global period listed on the attached questionnaire refers to the number of post-service days of care that are included in the payment for a global surgical package as determined by the Health Care Financing Administration for Medicare payment purposes. There are three categories of global services: 090 (90 days), 010 (10 days), 000 (0 days). Two other global periods may be used: XXX means that a global period does not apply to the code and ZZZ means that you would report this service in addition to the primary procedure and you should rate only the additional intra-service work of the service. Take into account any difference between the global period of the service that you are evaluating and that of the reference service that you are comparing it to.

Step 2: List one or two CPT code(s) from Table 1 that were important reference services in estimating the relative value of physician work for the service described in each questionnaire.

Step 3: Estimate the following service characteristics for the service you are rating and your key reference services:

Average Time (in Minutes): Estimate the average time, in minutes, involved in the pre-service, intra-service, and post-service portion of the service. You must refer to Appendix A for definitions of these time periods.

In considering post-service time for surgical services, please indicate each of the following:

- Time you spend on post-operative care on the day of the procedure;
- Total time you spend with the patient and the number of visits in the ICU after the day of the procedure;
- Total time you spend with the patient and the number of visits in the hospital after the day of the procedure and after any ICU days;
- Total time you spend with the patient and the number of visits in your office after discharge during the global period only.

Complexity/Intensity: For each component of work (see Appendix A for detailed definitions), indicate the level of complexity/intensity for each service on a scale from 1 to 5 (1 = least complex among all of the services you perform, 5 = most complex among all of the services you perform).

Step 4: Indicate if the physician work of performing this service has changed in the past 5 years.

Step 5 Consider whether the typical service/patient provided by your specialty society describes your typical patient.

QUESTIONNAIRE

CPT Code Number: _____

Global Period: _____

CPT Descriptor: _____

Typical Service/Patient: _____

Step 1 Estimate the Relative Value of Physician Work (work RVU): _____

Step 2 List one or two important reference services (Table 1) in estimating physician work for this code (List only the CPT code numbers for the reference services):

1) _____ 2) _____

Step 3 Estimate the following service characteristics for the code that you have rated and your key reference services:

Service Characteristic	CPT code that you have rated in Step 1	Reference Service 1 (from Step 2)	Reference Service 2 (from Step 2)
CPT Code			
TIME IN MINUTES (See Appendix A for detailed definitions of Time Periods)			
Pre-Service Time			
Intra-Service Time			
Post-Service Time:			
Day of Procedure			
ICU (Total Time/Number of Visits)	/	/	/
Other Hospital (Total Time/# of Visits)	/	/	/
Office (Total Time/Number of Visits)	/	/	/
Complexity/Intensity on a scale of 1 to 5 (1=least complex, 5=most complex) (See Appendix A for detailed definitions)			
Mental Effort and Judgment			
Technical Skill & Physical Effort			
Psychological Stress			

Step 4 Has the work of performing this service changed in the past 5 years? ___ Yes ___ No. If yes, complete a - c.

This service represents new technology that has become more familiar (i.e., less work). ___ I agree ___ I do not agree
 Patients requiring this service are now: ___ more complex (more work) ___ less complex (less work) ___ no change
 The usual site-of-service has changed: ___ from outpatient to inpatient ___ from inpatient to outpatient ___ no change

Step 5 Do you agree that the Typical Service/Patient provided above describes your typical patient? Yes ___ No ___

CPT Code	1995 Descriptor	1995 Work RVU	Global Period
Table 1			
4/6/95			
Colon and Rectal Surgery			
American Society of Colon and Rectal Surgeons			
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	0.55	XXX
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	0.96	000
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	1.01	000
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient(s) and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.	1.11	XXX
46050	Incision and drainage, perianal abscess, superficial	1.14	010
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	1.26	000
46604	Anoscopy; with dilation, any method	1.31	000
46221	Hemorrhoidectomy, by simple ligature (eg. rubber band)	1.38	010
46500	Injection of sclerosing solution, hemorrhoids	1.53	010

American Society of Colon and Rectal Surgeons 1

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CPT Code	1995 Descriptor	1995 Work RVU	Global Period
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.	1.71	XXX
91122	Anorectal manometry	1.77	000
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	1.96	000
44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.82	000
46200	Fissurectomy, with or without sphincterotomy	3.02	090
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70	000
46934	Destruction of hemorrhoids, any method; internal	3.84	090
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	4.01	000
46040	Incision and drainage of ischioanal and/or perirectal abscess (separate procedure)	4.90	090
46255	Hemorrhoidectomy, internal and external, simple;	4.95	090
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	5.31	000
46280	Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton	5.63	090
45383	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	5.87	000

American Society of Colon and Rectal Surgeons 2

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CPT Code	1995 Descriptor	1995 Work RVU	Global Period
44950	Appendectomy;	6.06	090
46700	Anoplasty, plastic operation for stricture; adult	6.40	090
46260	Hemorrhoidectomy, internal and external, complex or extensive;	6.70	090
45170	Excision of rectal tumor, transanal approach	9.40	090
49560	Repair initial incisional hernia; reducible	9.48	090
45130	Excision of rectal procidentia, with anastomosis; perineal approach	13.03	090
44120	Enterectomy, resection of small intestine; single resection and anastomosis	13.15	090
44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)	15.00	090
44150	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy	19.04	090
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)	21.29	090
44153	Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy	24.69	090

CPT five-digit codes, two-digit number modifiers, and descriptions only are copyright by the American Medical Association. No payment schedules, fee schedules, relative value units, scales, conversion factors, or components thereof are included in CPT. The AMA is not recommending that any specific relative values, fees, payment schedules, or related listings be attached to CPT. Any relative value scales or relative listings assigned to CPT codes are not those of the AMA, and the AMA is not recommending use of these relative values.

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Appendix A
Components of Physicians' Total Work
MAJOR SURGERY
(090 Global Period)

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specialty and specific service. Your specialty may have developed a more specific listing of potential services within each component. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

- Time it takes to perform the service.
- Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill required with respect to knowledge, training and actual experience necessary to perform the service. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.
- Psychological stress - Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor" the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

PRE-SERVICE PERIOD Before the Service, <u>May Include</u>	INTRA-SERVICE PERIOD Work <u>During the Service Is</u>	POST-SERVICE PERIOD After the Service, <u>May Include</u>
<p><u>Services provided from the day before the surgery until the time of the procedure:</u></p> <p>Hospital admission work-up.</p> <p>The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.</p> <p>Other pre-operative work may include dressing, scrubbing, and waiting before surgery, preparing patient and needed equipment for surgery, positioning the patient and other non "skin-to-skin" work in the OR.</p> <p>Excludes:</p> <ul style="list-style-type: none"> • Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57). • Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25). 	<p><u>Work while you perform the service</u> - "skin-to-skin" work including all intra-service activity that is normally included as a necessary part of the procedure.</p>	<p><u>Services provided within 90 days of the operation:</u></p> <p><u>Day of Procedure:</u></p> <p>Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits.</p> <p>Patient stabilization in the recovery room or special unit.</p> <p><u>Other follow-up care before the patient is discharged, if applicable:</u></p> <p>Post-operative visits, both in-hospital, if applicable, and out-patient office visits within 90 days of the operation</p> <p><u>Excludes:</u> Unrelated evaluation and management service provided during the postoperative period (reported with modifier -24)</p>

Appendix A
Components of Physicians' Total Work
MINOR SURGERY AND ENDOSCOPIES
(000 and 010 Global Period)

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specialty and specific service. Your specialty may have developed a more specific listing of potential services within each component. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

- Time it takes to perform the service.
- Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill required with respect to knowledge, training and actual experience necessary to perform the service. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.
- Psychological stress - Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor" the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

PRE-SERVICE PERIOD Before the Service, <u>May Include</u> .	INTRA-SERVICE PERIOD Work <u>During</u> the Service Is	POST-SERVICE PERIOD After the Service, <u>May Include</u>
<p><u>Services provided from the day before the surgery until the time of the procedure:</u></p> <p>Hospital admission work-up.</p> <p>The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.</p> <p>Other pre-operative work may include dressing, scrubbing, and waiting before surgery, preparing patient and needed equipment for surgery, positioning the patient and other non "skin-to-skin" work in the OR.</p> <p>Excludes:</p> <ul style="list-style-type: none"> ● Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57). ● Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25). 	<p><u>Work while you perform the service</u> -- "skin-to-skin" work including all intra-service activity that is normally included as a necessary part of the procedure.</p>	<p><u>Day of Procedure:</u></p> <p>Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits.</p> <p>Patient stabilization in the recovery room or special unit.</p> <p><u>Other follow-up care before the patient is discharged, if applicable:</u></p> <p>Post-procedure visits on the day of the procedure (global period = 000) or within 10 days of the procedure (global period = 010)</p> <p><u>Excludes:</u> Unrelated evaluation & management service provided during the postoperative period (reported with modifier -24)</p>

Appendix A

Components of Physicians' Total Work

EVALUATION AND MANAGEMENT SERVICES

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specialty and specific service. Your specialty may have developed a more specific listing of potential services within each component. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

- Time it takes to perform the service.
- Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill required with respect to knowledge, training and actual experience necessary to perform the service. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.
- Psychological stress - Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor" the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

	PRE-SERVICE PERIOD Before the Service, <u>May</u> Include	INTRA-SERVICE PERIOD Work <u>During</u> the Service Is	POST-SERVICE PERIOD After the Service, <u>May</u> Include
Office	<u>Preparing to see patient.</u> <u>Reviewing records.</u> <u>Communicating with other professionals.</u>	<u>Work while you are with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.</u>	<u>Arranging for further services.</u> <u>Reviewing results of studies.</u> <u>Communicating further with patient, family, and other professionals, including written and telephone reports.</u>
Hospital	<u>Work while not present on the patient's hospital unit or floor, including:</u> Communicating further with other professionals and the patient's family. Obtaining and/or reviewing the results of diagnostic and other studies. Written and telephone reports.	<u>Work while you are present on the patient's hospital unit or floor, including:</u> Reviewing the patient's chart. Seeing the patient. Writing notes. Communicating with other professionals and the patient's family	<u>Work while not present on the patient's hospital unit or floor, including:</u> Communicating further with other professionals and the patient's family. Obtaining and/or reviewing the results of diagnostic and other studies. Written and telephone reports.

Appendix A

Components of Physicians' Total Work

EMERGENCY MEDICINE

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specialty and specific service. Your specialty may have developed a more specific listing of potential services within each component. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

- Time it takes to perform the service.
- Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill required with respect to knowledge, training and actual experience necessary to perform the service. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.
- Psychological stress - Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor" the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

	PRE-SERVICE PERIOD Before the Service, <u>May Include</u>	INTRA-SERVICE PERIOD Work During the Service <u>Is</u>	POST-SERVICE PERIOD After the Service, <u>May Include</u>
Invasive		Work for the total service period may include: <u>Reviewing records, obtaining and interpreting test results or X-rays, and preparing to perform the service.</u> <u>Performing the service.</u> <u>Providing immediate postprocedural care before the patient is discharged or admitted to the hospital.</u> <u>Communicating with the patient, patient's family, and/or other professionals.</u> <u>Completing charts.</u>	
Evaluation/ Management		Work for the total service may include: <u>Reviewing records, obtaining and interpreting test results or X-rays, and preparing to perform the service.</u> <u>Seeing the patient.</u> <u>Communicating with the patient, patient's family, and/or other professionals.</u> <u>Completing charts.</u>	

Appendix A

Components of Physicians' Total Work

LABORATORY/IMAGING/OTHER NON-EVALUATION AND MANAGEMENT SERVICES

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specialty and specific service. Your specialty may have developed a more specific listing of potential services within each component. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

- Time it takes to perform the service.
- Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill required with respect to knowledge, training and actual experience necessary to perform the service. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.
- Psychological stress - Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor" the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

PRE-SERVICE PERIOD Before the Service, <u>May</u> Include:	INTRA-SERVICE PERIOD Work During the Service Is	POST-SERVICE PERIOD After the Service, <u>May</u> Include
For these services, the service period is treated as a whole and includes the work from the time you begin the service until you complete it and report your results, if applicable. Consider only the work that you do and not work done by technicians or other professionals. Do not include distinct evaluation and management services provided in addition to procedure in your estimate.		

SPECIALTY SPECIFIC DESCRIPTIONS

PRE-SERVICE PERIOD Before the Service, <u>May</u> Include:	INTRA-SERVICE PERIOD Work During the Service Is	POST-SERVICE PERIOD After the Service, <u>May</u> Include

FIVE-YEAR REVIEW MULTIDISCIPLINARY WORKGROUPS

<u>GROUPS</u>	<u>ASSIGNED TOPICS</u>	<u>SPECIALTY OF MEMBER</u>
<u>Group 1</u> Tracy R. Gordy, MD* William Rich, MD Neil Powe, MD Charles Mabry, MD	Neurosurgery Nursing/Home Visits Anesthesiology	Psychiatry Ophthalmology Internal Med Gen Surgery
<u>Group 2</u> L. Charles Novak, MD* W. Benson Harer, MD Alan Morris, MD Clay Molstad, MD	Psychiatry Card/Int Rad ER/Critical Care Other Med/Ther	Anesthesiology Ob/Gynecology Orthopaedics Internal Med
<u>Group 3</u> James Moorefield, MD* Eugene Weiner, MD J. L. Lichtenfeld, MD	Urology Ob/Gynecology Hosp Visits	Radiology Pediatric Surgery Internal Med
<u>Group 4</u> George F. Kwass, MD* James G. Hoehn, MD Kay K. Hanley, MD Meghan Gerety, MD	Card/Thor/Vasc Gastro/General Surgery	Pathology Plastic Surgery Pediatrics Geriatrics
<u>Group 5</u> James E. Hayes, MD* William Gee, MD John Tudor, Jr., MD	Speech/Lan/Hear Office Visits Imaging Lab/Pathology	Emergency Med Urology Family Practice
<u>Group 6</u> Ray E. Stowers, DO* Timothy J. Gardner, MD C. Schmidt, Jr., MD Walter L. Larimore, MD	Integumentary Ophthalmology	Osteopathic Med Cardiac Surg Psychiatry Family Practice
<u>Group 7</u> David L. McCaffree, MD* Michael D. Maves, MD James Fanale, MD	Orthopaedic Surg Podiatric Med	Otolaryngology Geriatrics
<u>Group 8</u> William L. Winters, MD* Robert Florin, MD John O. Gage, MD Richard Tuck, MD	Head/Neck/Ear/ Maxillofacial	Cardiology Neurosurgery General Surg Pediatrics

* indicates workgroup chair

KEY TO THE DATA REPORTS

Behind the specialty recommendation form for each code is a 2-page report assembling the following data for each code:

- Data from the HCFA-supplied tables for all the public and carrier medical director comments, including: 1995 RVUs and their source; the commenter's recommended RVUs; the ratio of the recommended to the 1995 RVUs; the frequency of claims for the service; and, the reference services identified by the commenter. For CMD comments, this report also includes the actual CMD comment.
- An AMA analysis of Medicare claims data provides substantial information about each service, including: beneficiary age and other characteristics; recent trends in claims frequency and site of service; specialties that provide the service; and, diagnosis codes reported on claims.
- Each code was also analyzed to assess: (1) any changes in RVUs for each service during the first four years of RBRVS implementation; (2) how the 1995 Medicare RVUs compare to the final RVUs from Phase IV of the Harvard RBRVS study; and (3) all the available data from the Harvard study on each code, including pre-, intra-, and post-service times, number and type of post-service visits, and the ratio of intra-service work to intra-service time.

Most of this information is labelled in a manner that makes it easy to understand. The last page of this KEY explains the AMA analysis, which is listed in the data reports in the boxes labelled Beneficiary Information, Frequency, Site of Service, Specialty Mix, and Claims-Level Diagnosis Information. The following documentation identifies what the numbers identified as "Source" mean, and what all the labels for the Harvard data mean.

Key to SOURCE for Codes Identified by Public Comments:

- 1 = Harvard
- 2 = HCFA
- 3 = Charge-based
- 4 = Refinement panel, retained published value
- 5 = Refinement panel, increased value
- 6 = Refinement panel, decreased value
- 7 = Other source
- 8 = RUC recommendation, accepted by HCFA
- 9 = RUC recommendation, increased by HCFA
- 10 = RUC recommendation, decreased by HCFA
- 11 = RUC recommendation, no change from published value
- 12 = Specialty society recommendation, accepted by HCFA
- 13 = Specialty society recommendation, increased by HCFA

- 14 = Specialty society recommendation, decreased by HCFA
- 15 = Specialty society recommendation, no change from published value
- 16 = Global period increased
- 17 = Global period decreased

Key to Harvard Data:

The data in the first two boxes of Harvard data summarize the differences in service work between the Harvard study and each of the Medicare Fee Schedules -- 1992 through 1995. In this way, the file provides a record of the evolution of the work RVUs since their initial complete publication. To make this comparison, all the codes are listed in 1995 RVUs. In other words, the effect of the 5.18% reduction for each service due to rescaling for budget neutrality has been eliminated. This allows you to identify services for which the RVUs have changed for reasons other than budget neutrality.

The labels are defined as follows:

modif	CPT two-digit modifier, if any
packhv	Harvard study global surgical package
pack95	MFS 95 global surgical package
desc95	1995 CPT descriptor
Hrvtotwk	Harvard study total work
MFSWK95	MFS 95 total work
ratio5h	ratio MFSWK95 to hrvtotwk
MFSWK92	MFS 95 total work
MFSWK93	MFS 94 total work
MFSWK94	MFS 93 total work
ratio2h	ratio MFSWK92 to hrvtotwk
ratio32	ratio MFSWK93 to MFSWK92
ratio43	ratio MFSWK94 to MFSWK93
ratio54	ratio MFSWK95 to MFSWK94
comm	identity of commenter
recwk	commenter's recommended total work value
amacod	AMA code for comment

Further Information --

- Global Period describes the global service packaging used in the Harvard study and in the MFS.
- Work RVUs are the total work RVUs for the MFS and for the Harvard RBRVS Study. The Harvard study amounts are those reported in the Harvard Phase III Final Report, unless indicated otherwise.
- Ratios describe the ratio of one Work RVU to another. A ratio greater than 1.0 indicates an increase in RVUs, a ratio less than 1.0 indicates a decrease.

The Harvard data in the other three boxes summarizes service work and time estimates for each code under review. The labels are defined as follows:

pack95	MFS 95 global surgical package
desc95	1995 CPT descriptor
hrvtotwk	Harvard study total work
notetw	denotes the service work was measured for the total service
pret	pre-service time, before O.R. entry
svdpre	indicates whether estimate is from a survey or prediction model (* = prediction)
itime	intra-service time
notett	denotes the service time was measured for the total service
imppt	immediate pre-and post operative time
svdimp	indicates whether estimate is from a survey or prediction model (* = prediction)
sdvis	number of later same day post visits
svdsdvis	indicates whether estimate is from a survey or prediction model (* = prediction)
sdvisdur	average duration of same day post visits
hvis	number of follow-up hospital visits after the day of surgery.
svdhvis	indicates whether estimate is from a survey or prediction model (* = prediction)
hvisdur	average duration of post-hospital visits
icuviz	number of follow-up hospital visits after the day of surgery that are in the ICU.
offvis	number of follow-up office visits after the day of surgery w/in global period.
svdoffd	indicates whether estimate is from a survey or prediction model (* = prediction)
offvdur	average duration of post-office visits
low_n	if equal to "j", indicates low number of survey responses for the Harvard estimate (N < 5)
recwk	total work value recommended by commenter
MFSWK95	1995 MFS total work value
sp	Harvard study specialty surveyed
phase	Harvard study phase service was studied in
twput	Harvard estimate of total work per minute (if relevant)
iwput	Harvard estimate of intra work per minute (if relevant)

Further Information:

- Specialty and phase (Source of Data) - The specialty surveyed in the Harvard Study is listed first (2-digit code), followed by an indicator of when the service was studied. An "n" indicates the time and work estimates are from the Harvard Study, with the intra-

service estimates derived from the phase I and II national surveys. A "3" indicates the time and work estimates are derived from the phase III surveys of technical expert panels. An 'xx' listed for specialty indicates two or more specialties were surveyed.

- Total Work - Estimate of total-service work. For the Harvard study estimates, the work values are derived primarily from the Harvard, Phase III results. The exceptions are for services where the global surgical period has been revised since the Harvard Study. For these services, the Harvard total work value has been adjusted to fit the new period. Harvard work values were multiplied by a constant factor to place them on the 1995 MFS scale of work.
- IWPUT - Harvard intra-work per unit time, equals intra work divided by intra time. If work and time were measured for the "total" service, work per unit time is equal to total work divided by total time (which is listed in the intra time column for these services). In these cases, total work per unit time is listed in parentheses under the total work estimate. This IWPUT is unadjusted for changes in work since the Harvard study.
- Pre- Before O.R. entry -- The amount of time (in minutes) spent by the surgeon on the day before and day of a procedure, up to admission to the operating room.
- Intra-Time -- The time spent by the physician performing the service itself (i.e. skin to skin time for incisional services or patient encounter time for office visits). For selected services, total rather than intra time is listed. These services are indicated with a "t" to the right of the time estimate.
- Immediate Pre-Post -- Immediate pre-and post operative time -- For surgical services, the amount of time spent by the surgeon from the admission to the operating room to the skin incision or beginning of the procedure, plus the time from skin closure until the patient leaves the operating room. For evaluation and management services, includes total pre- and post-service time.
- Later Same Day Post -- The amount of time spent by the surgeon after the patient leaves the recovery room on the day of the procedure. These data include the **number** and **duration** of surgeon post-operative visits to the patient during this period. The **Type** of visit is measured by minutes in increments of five.
- Hospital Post-Op -- The amount of time spent by the surgeon for in-hospital post-operative care after the day of the procedure. These data include the **number**, **duration**, and **ICU Visits** of surgeon post-operative visits to the patient during this period. The **Type** of visit is measured by minutes in increments of five.
- Office Post-Op -- The amount of time spent by the surgeon for post-operative care in the office after the day of the procedure. These data will include the **number**, and **duration** of post-operative visits to the patient during this period. The **Type** of visit is measured by minutes in increments of five.
- MFS95 Work -- The Medicare Fee Schedule Work Value for 1995.

AMA Procedure Profiles Analysis

The data reports present several selected types of information for each code under review in the five year review of the RBRVS. This information is intended to provide a "profile" of each code to assist AMA/Specialty Society RVS Update Committee in the evaluation of physician work.

The first box presents information on the characteristics of the beneficiaries that receive each service. The beneficiary characteristics data are from a 5% sample of Medicare physician/supplier claims for the first six months of 1994. These data provide information on a variety of factors which may be associated with health status or utilization. Included are information on the proportion of claims for beneficiaries that are: age 75 and over; age 85 and over; nonwhite; female; disabled only (non-aged, non-ESRD); ESRD only (non-aged, non-disabled), and; aged or disabled with ESRD. Location information is also provided -- in particular, the proportion of claims for the service that are provided in rural localities. (Rural localities are defined as Medicare payment localities that have more than 50% of the population outside of Metropolitan Statistical Areas (MSAs) according to the 1990 census.)

The second and third boxes provide frequency and site of service data from Medicare physician claims for 1992 and for the first half of 1994. These data are from HCFA's procedure summary files which contain information on virtually 100% of claims incurred in a given period. The 1994 frequency data are from the first six months of the year, and have been annualized for comparison with 1992 frequency. The average annual change in frequency and the average change in the hospital inpatient share of frequency are also presented.

The fourth box presents specialty mix information from the HCFA procedure summary file for the first six months of 1994. The specialties were ranked in descending order according to the share of total frequency for each code. The top eight specialties with at least 2% of total frequency for the code are displayed.

The last box presents information on the diagnosis of patients receiving each service. These data are also drawn from the 5% sample of Medicare physician/supplier claims for the first six months of 1994. Medicare physician/supplier claims contain up to four "claim-level" ICD9 diagnosis codes. These (typically five-digit) diagnosis codes have been truncated to three-digit codes. Table 1 reports the three-digit claim-level ICD9 codes most commonly reported for each service. The percentage reported is the number of times a diagnosis code was reported out of the total number of claim-level diagnosis codes possible for a service. (For example, if there are 10 claims for a given service then there are 40 possible claim-level diagnosis codes that could be reported.) Descriptors for the three-digit ICD9 codes are also provided.

Because the summary statistics for the beneficiary characteristics and diagnosis data are based on a sample of claims (rather than virtually 100% of claims as for the frequency, site of service and specialty mix data), these measures will be missing for many low-volume codes. There will also be some sampling error in these estimates, particularly among low-volume codes.

Specialty Society Acronyms

AAAI	American Academy of Allergy & Immunology
AACAP	American Academy of Child & Adolescent Psychiatry
AAD	American Academy of Dermatology
AAEM	American Association of Electrodiagnostic Medicine
AAFP	American Academy of Family Physicians
AAFPRS	American Academy of Facial Plastic and Reconstructive Surgery
AAN	American Academy of Neurology
AANS	American Association of Neurological Surgeons
AAO	American Academy of Ophthalmology
AAO-HNS	American Academy of Otolaryngology - Head and Neck Surgery, Inc.
AAOA	American Academy of Otolaryngic Allergy
AAOMS	American Academy of Oral and Maxillofacial Surgeons
AAOS	American Academy of Orthopaedic Surgeons
AAP	American Academy of Pediatrics
AAPA	American Academy of Physician Assistants
AAPM	American Academy of Pain Medicine
AAPMR	American Academy of Physical Medicine and Rehabilitation
AAPS	American Association of Plastic Surgeons
AATS	American Association for Thoracic Surgery
ACC	American College of Cardiology
ACCP	American College of Chest Physicians
ACEP	American College of Emergency Physicians
ACG	American College of Gastroenterology
ACNP	American College of Nuclear Physicians
ACOG	American College of Obstetricians and Gynecologists
ACP	American College of Physicians
ACPM	American College of Preventive Medicine
ACR	American College of Radiology
ACR _h	American College of Rheumatology
ACS	American College of Surgeons
AGA	American Gastroenterological Association
AGS	American Geriatrics Society
ALROS	American Laryngological, Rhinological, and Otological Society
AMA	Aerospace Medical Association
AMDA	American Medical Directors Association
AMSUS	Association Military Surgeons of the US

ANA	American Nurses Association
AOA	American Osteopathic Association
AOA-HCP	American Optometric Association
AOFAS	American Orthopaedic Foot and Ankle Society
AOTA	American Occupational Therapy Association
APA	American Psychiatric Association
APA-HCP	American Psychological Association
APMA	American Podiatric Medical Association
APSA	American Pediatric Surgical Association
APTA	American Physical Therapy Association
ASA	American Society of Anesthesiologists
ASAM	American Society of Addiction Medicine
ASAS	American Society of Abdominal Surgeons
ASC	American Society of Cytopathology
ASCO	American Society of Clinical Oncology
ASCP	American Society of Clinical Pathologists
ASCRS	American Society of Colon and Rectal Surgeons
ASCRS2	American Society of Cataract and Refractive Surgery
ASDS	American Society for Dermatologic Surgery, Inc.
ASGE	American Society for Gastrointestinal Endoscopy
ASGS	American Society of General Surgeons
ASH	American Society of Hematology
ASHA	American Speech-Language Hearing Association
ASIM	American Society of Internal Medicine
ASMS	American Society of Maxillofacial Surgeons
ASPRS	American Society of Plastic and Reconstructive Surgeons, Inc.
ASRM	American Society of Reconstructive Microsurgery
ASRM2	American Society of Reproductive Medicine
ASTRO	American Society for Therapeutic Radiology and Oncology
ATS	American Thoracic Society
AUA	American Urological Association
AUR	Association of University Radiologists
CAP	College of American Pathologists
CLAO	Contact Lens Association of Ophthalmologists
ICS-US	International College of Surgeons - US Section
JCAI	Joint Council of Allergy & Immunology
NASW	National Association of Social Workers
RPA	Renal Physicians Association
RSNA	Radiological Society of North America
SCCM	Society of Critical Care Medicine

SCVIR	Society of Cardiovascular & Interventional Radiology
SID	Society for Investigative Dermatology
SNM	Society of Nuclear Medicine
STS	Society of Thoracic Surgeons
SVS	The Society for Vascular Surgery

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS FIVE YEAR REVIEW OF THE RBRVS RECOMMENDATIONS

Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
10040	Acne surgery	1.34		0.80	3	Integumentary
10061	Drainage of skin abscess	2.48		2.24	3	Integumentary
10080	Drainage of pilonidal cyst	1.62		1.12	3	Integumentary
10140	Drainage of hematoma/fluid	1.48		1.48	2	Integumentary
11000	Surgical cleansing of skin	0.91		0.60	3	Integumentary
11001	Additional cleansing of skin	0.45		0.30	3	Integumentary
11043	Cleansing of tissue/muscle	1.83			6	Refer to CPT
11044	Cleansing of tissue/muscle/an	2.28			6	Refer to CPT
11101	Biopsy each added Lesion	0.41		0.41	2	Integumentary
11300	Shave skin lesion	0.51		0.51	2	Integumentary
11301	Shave skin lesion	0.85		0.85	2	Integumentary
11302	Shave skin lesion	1.05		1.05	2	Integumentary
11303	Shave skin lesion	1.24		1.24	2	Integumentary
11305	Shave skin lesion	0.67		0.67	2	Integumentary
11306	Shave skin lesion	0.99		0.99	2	Integumentary
11307	Shave skin lesion	1.14		1.14	2	Integumentary
11308	Shave skin lesion	1.41		1.41	2	Integumentary
11310	Shave skin lesion	0.73		0.73	2	Integumentary
11311	Shave skin lesion	1.05		1.05	2	Integumentary
11312	Shave skin lesion	1.20		1.20	2	Integumentary
11313	Shave skin lesion	1.62		1.62	2	Integumentary
11441	Removal of skin lesion	1.56		1.56	2	Integumentary
11710	Scraping of 1-5 nails	0.32			6	Refer to CPT
11711	Scraping of additional nails	0.20			6	Refer to CPT
11731	Removal of second nail plate	0.55		0.57	1	Integumentary
11732	Remove additional nail plate	0.38		0.57	1	Integumentary

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

KEY (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain budget neutrality; 6 = Refer to CPT; 7 = No RUC recommendation at this time.)

Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
11750	Removal nail bed	1.66		1.66	2	Integumentary
11752	Remove nail bed/finger tip	2.37		2.37	2	Integumentary
11762	Reconstruction of nail bed	2.84		2.84	2	Integumentary
11901	Added skin lesion injections	0.80		0.80	2	Integumentary
11960	Insert tissue expander(s)	6.04		8.00	4	Integumentary
11971	Removal of tissue expander(s)	1.51			6	Refer to CPT
13131	Repair of wound or lesion	3.74		3.74	2	Integumentary
13132	Repair of wound or lesion	4.21		5.75	4	Integumentary
13150	Repair of wound or lesion	3.76		3.76	2	Integumentary
13151	Repair of wound or lesion	4.40		4.40	2	Integumentary
13160	Late closure of wound	9.53		9.53	2	Integumentary
13300	Repair of wound or lesion	5.11			6	Refer to CPT
14300	Skin tissue rearrangement	10.76			6	Refer to CPT
15000	Skin graft procedure	1.85			6	Refer to CPT
15101	Skin split graft procedure	1.72			6	Refer to CPT
15121	Skin split graft procedure	2.67			6	Refer to CPT
15201	Skin full graft procedure	1.32			6	Refer to CPT
15221	Skin full graft procedure	1.19			6	Refer to CPT
15241	Skin full graft procedure	1.86			6	Refer to CPT
15261	Skin full graft procedure	2.23			6	Refer to CPT
15570	Form skin pedicle flap	3.75		8.39	4	Integumentary
15572	Form skin pedicle flap	3.80		8.59	4	Integumentary
15574	Form skin pedicle flap	3.85		8.79	4	Integumentary
15576	Form skin pedicle flap	4.27		7.85	4	Integumentary
15580	Attach skin pedicle graft	3.30		9.00	1	Integumentary
15732	Muscle-skin graft head/neck	12.10		16.52	4	Integumentary
15736	Muscle-skin graft arm	15.26		15.26	2	Integumentary
15738	Muscle-skin graft leg	10.07		16.52	4	Integumentary
15755	Microvascular flap procedure	28.33			6	Refer to CPT
15958	Remove thigh pressure sore	13.89		13.89	2	Integumentary

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Code	Descriptor	1995 RVU	RUC Rec RVU	Key	Topic
16000	Initial treatment of burn(s)	0.89	0.89	2	Integumentary
16035	Incision of burn scab	4.53	4.53	2	Integumentary
17000	Destroy benign/premal lesion	0.64	0.64	2	Integumentary
17001	Destruction of add'l lesions	0.19	0.19	2	Integumentary
17002	Destruction of add'l lesions	0.19	0.19	2	Integumentary
17106	Destruction of skin lesions	4.54	4.54	2	Integumentary
17107	Destruction of skin lesions	9.06	9.06	2	Integumentary
17108	Destruction of skin lesions	13.10	13.10	2	Integumentary
17304	Chemosurgery of skin lesion	7.60	7.60	2	Potentially Overvalued Services
19120	Removal of breast lesion	4.84	5.35	4	Integumentary
19140	Removal of breast tissue	4.90	4.85	3	Integumentary
19160	Removal of breast tissue	6.65	5.75	3	Integumentary
19180	Removal of breast	8.15	8.09	3	Integumentary
19318	Reduction of large breast	11.08	15.00	4	Integumentary
19325	Enlarge breast with implant	8.05	8.05	2	Integumentary
19350	Breast reconstruction	8.21	8.52	4	Integumentary
20225	Bone biopsy trocar/needle	1.87	1.87	2	Orthopaedic Surgery
21015	Resection of facial tumor	4.94	4.94	2	Potentially Overvalued Services
21025	Excision of bone lower jaw	5.03	8.92	1	Otolaryngology
21030	Removal of face bone lesion	7.05	6.04	5	Otolaryngology
21031	Remove exostosis mandible	2.01	3.14	4	Otolaryngology
21032	Excision of exostosis maxilla	4.27	3.14	5	Otolaryngology
21041	Removal of jaw bone lesion	5.03	6.04	4	Otolaryngology
21110	Interdental fixation	5.03	5.03	2	Otolaryngology
21125	Augmentation lower jaw bone	6.22	6.22	2	Otolaryngology
21150	Reconstruct midface lefort	24.41	24.41	2	Otolaryngology
21188	Reconstruction of midface	21.47	21.47	2	Otolaryngology
21194	Reconstruct lower jaw bone	18.81	18.81	2	Otolaryngology
21243	Reconstruction of jaw joint	18.98	18.98	2	Otolaryngology
21270	Augmentation cheek bone	12.10	12.10	2	Otolaryngology

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
21320	Treatment of nose fracture	1.82		1.82	2	Otolaryngology
21330	Repair of nose fracture	5.03		5.03	2	Otolaryngology
21338	Repair nasaoethmoid fracture	6.04		6.04	2	Otolaryngology
21339	Repair nasaoethmoid fracture	7.56		7.56	2	Otolaryngology
21435	Repair craniofacial fracture	16.12		16.12	2	Otolaryngology
21453	Treat lower jaw fracture	5.18		5.18	2	Otolaryngology
21462	Repair lower jaw fracture	9.15		9.15	2	Otolaryngology
21485	Reset dislocated jaw	3.73		3.73	2	Otolaryngology
21610	Partial removal of rib	8.54		13.66	4	Orthopaedic Surgery
21930	Remove lesion back or flank	6.55		4.82	3	General Surgery
22151	Reconstruct thorax spine	22.15			6	Refer to CPT
22210	Revision of neck spine	22.51			6	Refer to CPT
22315	Treat spine fracture	8.36			6	Refer to CPT
22327	Repair thorax spine fracture	17.56			6	Refer to CPT
22554	Neck spine fusion	18.14			6	Refer to CPT
22558	Lumbar spine fusion	22.12			6	Refer to CPT
22610	Thorax spine fusion	15.11			6	Refer to CPT
22612	Lumbar spine fusion	22.25			6	Refer to CPT
22800	Fusion of spine	16.92			6	Refer to CPT
22802	Fusion of spine	31.31			6	Refer to CPT
22812	Fusion of spine	27.20			6	Refer to CPT
22840	Insert spine fixation device	12.54			6	Refer to CPT
22842	Insert spine fixation device	14.42			6	Refer to CPT
22845	Insert spine fixation device	12.48			6	Refer to CPT
22849	Removal of anterior instrume	12.86		17.55	1	Neurosurgery
22855	Removal of anterior instrume	9.10		14.11	1	Neurosurgery
22900	Remove abdominal wall lesio	6.56		5.13	3	General Surgery
23222	Partial removal of humerus	16.64		22.78	1	Orthopaedic Surgery
23395	Muscle transfer shoulder/arm	12.42		16.00	1	Orthopaedic Surgery
23420	Repair of shoulder	12.60		12.60	2	Orthopaedic Surgery

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
23466	Repair shoulder capsule	13.65		13.65	2	Orthopaedic Surgery
23472	Reconstruct shoulder joint	16.09		16.09	2	Orthopaedic Surgery
23615	Repair humerus fracture	8.38		8.38	2	Orthopaedic Surgery
23802	Fusion of shoulder joint	14.67		15.62	4	Orthopaedic Surgery
23920	Amputation at shoulder joint	13.60		13.60	2	Orthopaedic Surgery
24363	Replace elbow joint	17.66		17.66	2	Orthopaedic Surgery
24435	Repair humerus with graft	12.19		12.19	2	Orthopaedic Surgery
24546	Repair humerus fracture	14.66		14.66	2	Orthopaedic Surgery
25065	Biopsy forearm soft tissue	2.39		1.94	3	Potentially Overvalued Services
25107	Remove wrist joint cartilage	5.89		5.89	2	Orthopaedic Surgery
25115	Remove wrist/forearm lesion	6.26		8.00	4	Orthopaedic Surgery
25420	Repair/graft radius and ulna	15.34		15.34	2	Orthopaedic Surgery
25446	Wrist replacement	15.52		15.52	2	Orthopaedic Surgery
25575	Repair fracture radius/ulna	9.47		9.47	2	Orthopaedic Surgery
25628	Repair wrist bone fracture	7.81		7.81	2	Orthopaedic Surgery
25810	Fusion/graft of wrist joint	9.79		9.79	2	Orthopaedic Surgery
26010	Drainage of finger abscess	1.49		1.49	2	Orthopaedic Surgery
26123	Release palm contracture	8.64		8.64	2	Orthopaedic Surgery
26356	Repair finger/hand tendon	7.05		7.05	2	Orthopaedic Surgery
26442	Release palm and finger tendo	6.10		7.45	4	Orthopaedic Surgery
26449	Release forearm/hand tendon	6.39		6.39	2	Orthopaedic Surgery
26531	Revise knuckle with implant	7.57		7.57	2	Orthopaedic Surgery
26992	Drainage of bone lesion	13.97		12.30	3	Potentially Overvalued Services
27001	Incision of hip tendon	7.70		6.50	3	Potentially Overvalued Services
27006	Incision of hip tendons	9.50		9.00	3	Potentially Overvalued Services
27040	Biopsy of soft tissues	3.26		2.71	3	Potentially Overvalued Services
27049	Remove tumor hip/pelvis	12.52		12.52	2	Orthopaedic Surgery
27052	Biopsy of hip joint	5.45		5.45	2	Orthopaedic Surgery
27076	Extensive hip surgery	17.93		20.23	4	Orthopaedic Surgery
27090	Removal of hip prosthesis	12.00		10.34	3	Potentially Overvalued Services

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Code	Descriptor	1995 RVU	RUC Rec RVU	Key	Topic
27134	Revise hip joint replacement	24.54	27.00	4	Orthopaedic Surgery
27137	Revise hip joint replacement	18.67	18.67	2	Orthopaedic Surgery
27138	Revise hip joint replacement	18.93	18.93	2	Orthopaedic Surgery
27146	Incision of hip bone	13.72	16.55	1	Orthopaedic Surgery
27147	Revision of hip bone	17.58	19.70	1	Orthopaedic Surgery
27151	Incision of hip bones	18.58	21.50	1	Orthopaedic Surgery
27156	Revision of hip bones	20.16	23.62	1	Orthopaedic Surgery
27181	Repair slipped epiphysis	13.80	13.80	2	Orthopaedic Surgery
27227	Treat hip fracture(s)	15.39	22.00	1	Orthopaedic Surgery
27228	Treat hip fracture(s)	17.90	25.59	4	Orthopaedic Surgery
27259	Repair of hip dislocation	18.03	20.50	1	Orthopaedic Surgery
27265	Treatment of hip dislocation	5.58	4.74	3	Potentially Overvalued Services
27266	Treatment of hip dislocation	7.73	6.96	3	Potentially Overvalued Services
27284	Fusion of hip joint	15.62	15.62	2	Orthopaedic Surgery
27286	Fusion of hip joint	15.65	15.65	2	Orthopaedic Surgery
27323	Biopsy thigh soft tissues	2.67	2.23	3	Potentially Overvalued Services
27329	Remove tumor thigh/knee	11.74	13.00	4	Orthopaedic Surgery
27365	Extensive leg surgery	13.84	15.00	4	Orthopaedic Surgery
27397	Transplants of thigh tenons	9.33	10.53	4	Orthopaedic Surgery
27428	Reconstruction knee	10.68	13.28	1	Orthopaedic Surgery
27429	Reconstruction knee	11.86	14.67	4	Orthopaedic Surgery
27435	Incision of knee joint	8.74	8.74	2	Orthopaedic Surgery
27454	Realignment of thigh bone	12.26	16.55	4	Orthopaedic Surgery
27457	Realignment of Knee	12.60	12.60	2	Orthopaedic Surgery
27486	Revise knee joint replace	16.63	18.00	4	Orthopaedic Surgery
27487	Revise knee joint replace	21.69	21.69	2	Orthopaedic Surgery
27488	Removal of knee prosthesis	14.48	14.48	2	Orthopaedic Surgery
27506	Repair of thigh fracture	15.93	15.93	2	Orthopaedic Surgery
27513	Treatment of thigh fracture	16.78	16.78	2	Orthopaedic Surgery
27536	Repair of knee fracture	14.51	14.51	2	Orthopaedic Surgery

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
27550	Treat knee fracture(s)	5.53		5.53	2	Potentially Overvalued Services
27580	Fusion of knee	12.26		18.20	4	Orthopaedic Surgery
27607	Treat lower leg bone lesion	7.05		7.05	2	Orthopaedic Surgery
27712	Realignment of lower leg	11.81		13.20	4	Orthopaedic Surgery
27724	Repair/graft of tibia	12.11		13.88	4	Orthopaedic Surgery
27725	Repair of lower leg	11.04		14.50	1	Orthopaedic Surgery
27759	Repair of tibia fracture	12.60		12.60	2	Orthopaedic Surgery
27827	Treat lower leg fracture	9.90		12.95	4	Orthopaedic Surgery
27828	Treat lower leg fracture	12.33		15.12	4	Orthopaedic Surgery
27870	Partial removal of hip bone	10.42		13.00	1	Orthopaedic Surgery
27894	Decompression of leg	7.64		9.13	4	Orthopaedic Surgery
28002	Treatment of foot infection	3.76		3.76	2	Orthopaedic Surgery
28010	Incision of toe tendon	2.97			7	Potentially Overvalued Services
28080	Removal of foot lesion	3.18		3.18	2	Podiatry
28113	Part removal of metatarsal	4.09		4.23	4	Podiatry
28114	Removal of metatarsal heads	7.16		7.16	2	Podiatry
28116	Revision of foot	6.17		7.00	4	Orthopaedic Surgery
28120	Part removal of ankle/heel	4.81		4.81	2	Podiatry
28130	Removal of ankle bone	7.33		7.33	2	Orthopaedic Surgery
28190	Removal of foot foreign body	1.91		1.91	2	Podiatry
28200	Repair of foot tendon	4.45		4.45	2	Podiatry
28202	Repair/graft of foot tendon	6.38		6.38	2	Podiatry
28208	Repair of foot tendon	4.11		4.11	2	Podiatry
28220	Release of foot tendon	4.27		4.27	2	Podiatry
28222	Release of foot tendons	5.36		5.36	2	Podiatry
28225	Release of foot tendon	3.42		3.42	2	Podiatry
28226	Release of foot tendons	4.27		4.27	2	Podiatry
28230	Incision of foot tendon(s)	4.00		4.00	2	Podiatry
28232	Incision of toe tendon	3.26		3.26	2	Podiatry
28234	Incision of foot tendon	3.19		3.19	2	Podiatry

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
28238	Revision of foot tendon	7.27		7.27	2	Podiatry
28261	Revision of foot tendon	8.92		10.95	4	Orthopaedic Surgery
28262	Revision of foot and ankle	12.19		15.00	1	Orthopaedic Surgery
28270	Release of foot contracture	4.58		4.58	2	Podiatry
28272	Release of toe joint each	3.67		3.67	2	Podiatry
28285	Repair of hammertoe	4.41		4.41	2	Podiatry
28288	Partial removal of foot bone	3.73		4.23	4	Podiatry
28292	Correction of bunion	6.24		6.24	2	Podiatry
28293	Correction of bunion	8.25		8.25	2	Podiatry
28299	Correction of bunion	8.46		8.46	2	Podiatry
28309	Incision of metatarsa	18.83		12.00	1	Orthopaedic Surgery
28341	Resect enlarged toe	7.86		7.86	2	Podiatry
28344	Repair extra toe(s)	3.89		3.89	2	Podiatry
28415	Repair of heel fracture	13.28		15.00	1	Orthopaedic Surgery
28476	Repair metatarsal fracture	3.15		3.15	2	Podiatry
28496	Repair big toe fracture	2.18		2.18	2	Podiatry
28531	Treat sesamoid bone fracture	2.01		2.01	2	Podiatry
28576	Treat foot dislocation	3.75		3.75	2	Podiatry
28615	Repair foot dislocation	5.12		6.99	4	Orthopaedic Surgery
28636	Treat toe dislocation	2.67		2.67	2	Podiatry
28666	Treat toe dislocation	2.56		2.56	2	Podiatry
28705	Fusion of foot bones	14.23		14.23	2	Orthopaedic Surgery
28715	Fusion of foot bones	12.18		12.18	2	Orthopaedic Surgery
28730	Fusion of foot bones	9.91		9.91	2	Orthopaedic Surgery
28735	Fusion of foot bones	10.07		10.07	2	Orthopaedic Surgery
28737	Revision of foot bones	8.89		8.89	2	Orthopaedic Surgery
28740	Fusion of foot bones	6.20		7.40	4	Orthopaedic Surgery
28750	Fusion of big toe joint	4.77		6.90	4	Orthopaedic Surgery
28755	Fusion of big toe joint	4.48		4.48	2	Podiatry
28760	Fusion of big toe joint	5.47		7.00	4	Orthopaedic Surgery

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29700	Removal/revision of cast	0.88		0.57	3	Orthopaedic Surgery
29705	Removal/revision of cast	1.12		0.76	3	Orthopaedic Surgery
29840	Wrist arthroscopy	5.39		5.39	2	Orthopaedic Surgery
29843	Wrist arthroscopy/surgery	5.86		5.86	2	Orthopaedic Surgery
29844	Wrist arthroscopy/surgery	6.22		6.22	2	Orthopaedic Surgery
29845	Wrist arthroscopy/surgery	7.34		7.34	2	Orthopaedic Surgery
29846	Wrist arthroscopy/surgery	6.60		6.60	2	Orthopaedic Surgery
29847	Wrist arthroscopy/surgery	6.93		6.93	2	Orthopaedic Surgery
29848	Wrist arthroscopy/surgery	4.04		4.04	2	Orthopaedic Surgery
29876	Knee arthroscopy/surgery	7.51		7.51	2	Orthopaedic Surgery
29882	Knee arthroscopy/surgery	8.24		8.24	2	Orthopaedic Surgery
29889	Knee arthroscopy/surgery	10.76		14.41	4	Orthopaedic Surgery
30020	Drainage of nose lesion	1.38		1.38	2	Otolaryngology
30545	Repair nasal defect	10.89		10.89	2	Otolaryngology
30903	Control of nosebleed	1.54		1.54	2	Otolaryngology
30905	Control of nosebleed	1.97		1.97	2	Otolaryngology
30906	Repeat control of nosebleed	2.45		2.45	2	Otolaryngology
30920	Ligation upper jaw artery	7.46		8.79	1	Otolaryngology
31090	Exploration of sinuses	8.65			6	Refer to CPT
31225	Removal of upper jaw	15.19		17.50	4	Otolaryngology
31230	Removal of upper jaw	21.06		20.00	5	Otolaryngology
31290	Nasal/sinus endoscopy surg	12.87		16.05	1	Otolaryngology
31291	Nasal/sinus endoscopy surg	13.52		17.00	1	Otolaryngology
31292	Nasal/sinus endoscopy surg	10.45		13.83	1	Otolaryngology
31293	Nasal/sinus endoscopy surg	11.43		15.15	1	Otolaryngology
31294	Nasal/sinus endoscopy surg	13.06		18.00	1	Otolaryngology
31320	Diagnostic incision larynx	4.54		4.54	2	Otolaryngology
31360	Removal of larynx	15.19		15.19	2	Otolaryngology
31365	Removal of larynx	21.83		21.83	2	Otolaryngology
31367	Partial removal of larynx	18.98		18.98	2	Otolaryngology

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Code	Descriptor	1995 RVU	RUC Rec RVU	Key	Topic
31368	Partial removal of larynx	23.72	23.72	2	Otolaryngology
31370	Partial removal of larynx	18.50	18.50	2	Otolaryngology
31380	Partial removal of larynx	18.50	18.50	2	Otolaryngology
31382	Partial removal of larynx	18.50	18.50	2	Otolaryngology
31390	Removal of larynx and pharynx	21.15	25.00	1	Otolaryngology
31395	Reconstruct larynx and pharynx	26.19	28.00	1	Otolaryngology
31400	Revision of larynx	9.06	9.06	2	Otolaryngology
31502	Change of windpipe airway	0.65	0.65	2	Otolaryngology
31513	Injection into vocal cord	2.10	2.10	2	Otolaryngology
31520	Diagnostic laryngoscopy	2.56	2.56	2	Potentially Overvalued Services
31531	Operative laryngoscopy	3.73	3.79	4	Otolaryngology
31536	Operative laryngoscopy	3.17	3.56	4	Otolaryngology
31541	Operative laryngoscopy	3.56	4.53	4	Otolaryngology
31561	Operative laryngoscopy	4.90	5.86	4	Otolaryngology
31571	Laryngoscopy with injection	3.52	4.27	4	Otolaryngology
31580	Revision of larynx	11.01	11.01	2	Otolaryngology
31587	Revision of larynx	7.98	10.00	1	Otolaryngology
31600	Incision of windpipe	3.62	3.62	2	Otolaryngology
31601	Incision of windpipe	4.45	4.45	2	Otolaryngology
31603	Incision of windpipe	4.15	4.15	2	Otolaryngology
31610	Incision of windpipe	7.87	7.87	2	Otolaryngology
31611	Surgery/speech prosthesis	5.03	5.03	2	Otolaryngology
31614	Repair windpipe opening	6.11	6.11	2	Otolaryngology
31750	Repair of windpipe	9.05	11.73	4	Otolaryngology
31780	Reconstruct windpipe	16.14	16.14	2	Otolaryngology
32000	Drainage of chest	1.54	1.54	2	Cardiothoracic Surgery
32020	Insertion of chest tube	3.98	3.98	2	Cardiothoracic Surgery
32100	Exploration/biopsy of chest	10.07	10.07	2	Cardiothoracic Surgery
32440	Removal of lung	19.15	19.15	2	Cardiothoracic Surgery
32480	Partial removal of lung	16.84	16.84	2	Cardiothoracic Surgery

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32500	Partial removal of lung	13.10		13.10	2	Cardiothoracic Surgery
32602	Thoracoscopy diagnostic	5.96		5.96	2	Cardiothoracic Surgery
33010	Drainage of heart sac	2.24		2.24	2	Cardiothoracic Surgery
33208	Insertion of heart pacemaker	7.28		7.28	2	Cardiothoracic Surgery
33244	Remove generator	8.34		8.34	2	Cardiothoracic Surgery
33425	Repair of mitral valve	25.57		25.57	2	Cardiothoracic Surgery
33426	Repair of mitral valve	26.07		29.42	4	Cardiothoracic Surgery
33427	Repair of mitral valve	32.07		32.07	2	Cardiothoracic Surgery
33510	CABG vein single	23.29		23.29	2	Cardiothoracic Surgery
33511	CABG vein two	25.57		25.57	2	Cardiothoracic Surgery
33512	CABG vein three	27.84		27.84	2	Cardiothoracic Surgery
33513	CABG vein four	30.12		30.12	2	Cardiothoracic Surgery
33514	CABG vein five	32.39		32.39	2	Cardiothoracic Surgery
33516	CABG vein six+	34.66		34.66	2	Cardiothoracic Surgery
33530	Coronary artery bypass/reop	5.86		5.86	2	Cardiothoracic Surgery
33533	CABG arterial single	24.00		24.00	2	Cardiothoracic Surgery
33534	CABG arterial two	26.99		26.99	2	Cardiothoracic Surgery
33535	CABG arterial three	26.98		26.98	2	Cardiothoracic Surgery
33536	CABG arterial four+	32.96		32.96	2	Cardiothoracic Surgery
33870	Transverse aortic arch graft	37.74		37.74	2	Cardiothoracic Surgery
33875	Thoracic aorta graft	26.94		31.23	1	Cardiothoracic Surgery
33970	Aortic circulation assist	8.05			7	Potentially Overvalued Services
34201	Removal of artery clot	8.04		8.04	2	Cardiothoracic Surgery
35081	Repair defect of artery	22.15		26.23	4	Cardiothoracic Surgery
35082	Repair artery rupture aorta	28.82		34.20	4	Cardiothoracic Surgery
35091	Repair defect of artery	28.10		33.16	4	Cardiothoracic Surgery
35102	Repair defect of artery	23.44		28.80	4	Cardiothoracic Surgery
35301	Rechanneling of artery	15.95		17.79	4	Cardiothoracic Surgery
35470	Repair arterial blockage	8.63		8.63	2	Cardiology/Interventional Radiology
35471	Repair arterial blockage	10.07		10.07	2	Cardiology/Interventional Radiology

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Code	Descriptor	1995 RVU	RUC Rec RVU	Key	Topic
35472	Repair arterial blockage	6.91	6.91	2	Cardiology/Interventional Radiology
35473	Repair arterial blockage	6.04	6.04	2	Cardiology/Interventional Radiology
35474	Repair arterial blockage	7.36	7.36	2	Cardiology/Interventional Radiology
35475	Repair arterial blockage	9.49	9.49	2	Cardiology/Interventional Radiology
35476	Repair venous blockage	6.04	6.04	2	Cardiology/Interventional Radiology
35490	Atherectomy percutaneous	11.08	11.08	2	Cardiology/Interventional Radiology
35491	Atherectomy percutaneous	7.61	7.61	2	Cardiology/Interventional Radiology
35492	Atherectomy percutaneous	6.65	6.65	2	Cardiology/Interventional Radiology
35493	Atherectomy percutaneous	8.10	8.10	2	Cardiology/Interventional Radiology
35494	Atherectomy percutaneous	10.44	10.44	2	Cardiology/Interventional Radiology
35495	Atherectomy percutaneous	9.49	9.49	2	Cardiology/Interventional Radiology
35556	Artery bypass graft	15.47	19.37	4	Cardiothoracic Surgery
35566	Artery bypass graft	20.21	24.45	4	Cardiothoracic Surgery
35583	Vein bypass graft	15.97	20.03	4	Cardiothoracic Surgery
35585	Vein bypass graft	19.05	25.92	4	Cardiothoracic Surgery
35654	Artery bypass graft	17.62	17.62	2	Cardiothoracic Surgery
35656	Artery bypass graft	13.86	17.84	4	Cardiothoracic Surgery
35681	Artery bypass graft	8.05	3.93	3	Cardiothoracic Surgery
35875	Removal of clot in graft	9.07	8.19	3	Cardiothoracic Surgery
36010	Place catheter in vein	2.43	2.43	2	Potentially Overvalued Services
36215	Place catheter in artery	4.47	4.68	4	Cardiothoracic Surgery
36218	Place catheter in artery	1.01	1.01	4	Cardiothoracic Surgery
36245	Place catheter in artery	5.07	4.68	5	Cardiothoracic Surgery
36248	Place catheter in artery	1.01	1.01	4	Cardiothoracic Surgery
36489	Insertion of catheter vein	1.22	1.22	2	Cardiothoracic Surgery
36520	Plasma and/or cell exchange	1.74	1.74	2	Cardiothoracic Surgery
36533	Insertion of access port	3.82	5.00	1	Cardiothoracic Surgery
36534	Revision of access port	3.79	2.73	3	Cardiothoracic Surgery
36620	Insertion catheter artery	1.15	1.15	2	Cardiothoracic Surgery
36821	Artery-vein fusion	8.39	8.39	2	Potentially Overvalued Services

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Code	Descriptor	1995 RVU	RUC Rec RVU	Key	Topic
36830	Artery-vein graft	7.78	11.25	1	Cardiothoracic Surgery
37201	Transcatheter therapy infuse	7.25	7.25	2	Potentially Overvalued Services
37205	Transcatheter stent	8.28	8.28	2	Cardiology/Interventional Radiology
37206	Transcatheter stent	4.13	4.13	2	Cardiology/Interventional Radiology
37730	Removal of leg veins	6.63	6.63	2	Cardiothoracic Surgery
38230	Bone marrow collection	3.16	4.22	4	Pathology
38720	Removal of lymph nodes neck	12.29	12.29	2	Otolaryngology
38724	Removal of lymph nodes neck	13.22	13.22	2	Otolaryngology
39400	Visualization of chest	5.11	5.11	2	Cardiothoracic Surgery
40806	Incision of lip fold	0.31	0.31	2	Otolaryngology
40808	Biopsy of mouth lesion	0.91	0.91	2	Otolaryngology
40820	Treatment of mouth lesion	1.23	1.23	2	Otolaryngology
40843	Reconstruction of mouth	11.63	11.63	2	Otolaryngology
41000	Drainage of mouth lesion	1.25	1.25	2	Otolaryngology
41005	Drainage of mouth lesion	1.21	1.21	2	Otolaryngology
41010	Incision of tongue fold	1.19	1.01	3	Potentially Overvalued Services
41112	Excision of tongue lesion	2.63	2.63	2	Otolaryngology
41113	Excision of tongue lesion	3.09	3.09	2	Otolaryngology
41115	Excision of tongue fold	1.69	1.69	2	Otolaryngology
41116	Excision of mouth lesion	2.36	2.36	2	Otolaryngology
41135	Tongue and neck surgery	14.29	21.15	1	Otolaryngology
41145	Tongue removal neck surgery	27.58	27.58	2	Otolaryngology
41150	Tongue mouth jaw surgery	19.36	21.00	1	Otolaryngology
41155	Tongue jaw and neck surgery	23.40	25.60	1	Otolaryngology
41252	Repair tongue laceration	2.92	2.92	2	Otolaryngology
42106	Excision lesion mouth roof	2.63	2.05	3	Otolaryngology
42120	Remove palate/lesion	5.39	5.39	2	Otolaryngology
42145	Repair palate pharynx/uvula	7.04	7.04	2	Otolaryngology
42182	Repair palate	3.78	3.78	2	Otolaryngology
42200	Reconstruct cleft palate	9.48	11.25	4	Otolaryngology

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
42210	Reconstruct cleft palate	10.02		13.75	4	Otolaryngology
42260	Repair nose to lip fistula	4.17		9.18	1	Otolaryngology
42305	Drainage of salivary gland	5.59		5.59	2	Otolaryngology
42320	Drainage of salivary gland	2.30		2.30	2	Otolaryngology
42340	Removal of salivary stone	4.47		4.47	2	Otolaryngology
42415	Excise parotid gland/lesion	16.12		16.12	2	Otolaryngology
42426	Excise parotid gland/lesion	19.88		19.88	2	Otolaryngology
42500	Repair salivary duct	4.06		4.06	2	Otolaryngology
42505	Repair salivary duct	5.92		5.92	2	Otolaryngology
42507	Parotid duct diversion	5.96		5.96	2	Otolaryngology
42508	Parotid duct diversion	8.64		8.64	2	Otolaryngology
42720	Drainage of throat abscess	2.61		4.53	4	Otolaryngology
42725	Drainage of throat abscess	7.60		9.50	1	Otolaryngology
42809	Remove pharynx foreign body	1.76		1.76	2	Otolaryngology
42815	Excision of neck cyst	6.75		6.75	2	Otolaryngology
42820	Remove tonsils and adenoids	3.59		3.59	2	Otolaryngology
42880	Excise nose/throat lesion	6.01			6	Refer to CPT
42961	Control throat bleeding	5.18		5.18	2	Otolaryngology
42962	Control throat bleeding	6.64		6.64	2	Otolaryngology
42972	Control nose/throat bleeding	6.55		6.55	2	Otolaryngology
43200	Esophagus endoscopy	1.59		1.59	2	Otolaryngology
43235	Upper GI endoscopy diagnosis	2.39		2.39	2	General Surgery
43239	Upper GI endoscopy biopsy	2.69		2.69	2	General Surgery
43260	Endoscopy bile duct/pancreas	5.96		5.96	2	General Surgery
43262	Endoscopy bile duct/pancreas	7.39		7.39	2	General Surgery
43420	Repair esophagus opening	10.19		10.19	2	General Surgery
43456	Dilate esophagus	3.52		2.57	3	General Surgery
43610	Excision of stomach lesion	10.11		10.11	2	General Surgery
43750	Place gastrostomy tube	5.71		4.27	5	General Surgery
43830	Place gastrostomy tube	4.84		7.50	1	General Surgery

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44010	Incision of small bowel	9.24		9.24	2	General Surgery
44020	Exploration of small bowel	10.69		10.69	2	General Surgery
44140	Partial removal of colon	16.97		16.97	2	General Surgery
44141	Partial removal of colon	17.36		17.36	2	General Surgery
44143	Partial removal of colon	15.00		17.36	4	General Surgery
44144	Partial removal of colon	15.00		16.97	4	General Surgery
44145	Partial removal of colon	21.29		21.29	2	General Surgery
44152	Removal of colon/ileostomy	22.98		22.98	2	General Surgery
44160	Removal of colon	14.09		14.09	2	General Surgery
44322	Colostomy with biopsies	10.31		10.31	2	General Surgery
44388	Colon endoscopy	2.82		2.82	2	General Surgery
44389	Colonoscopy with biopsy	3.13		3.13	2	General Surgery
44390	Colonoscopy for foreign body	3.83		3.83	2	General Surgery
44391	Colonoscopy for bleeding	4.32		4.32	2	General Surgery
44392	Colonoscopy and polypectomy	3.82		3.82	2	General Surgery
44393	Colonoscopy lesion removal	4.84		4.84	2	General Surgery
44394	Colonoscopy w/ snare	4.43		4.43	2	General Surgery
44950	Appendectomy	6.06		6.06	2	General Surgery
45110	Removal of rectum	21.68		21.68	2	General Surgery
45303	Proctosigmoidoscopy	0.50		0.80	1	General Surgery
45378	Diagnostic colonoscopy	3.70		3.70	2	General Surgery
45380	Colonoscopy and biopsy	4.01		4.01	2	General Surgery
45550	Repair rectum remove sigmoi	13.38		16.97	1	General Surgery
46040	Incision of rectal abscess	4.90		4.41	3	General Surgery
46255	Hemorrhoidectomy	4.95		4.95	2	General Surgery
46260	Hemorrhoidectomy	6.70		6.70	2	General Surgery
46261	Remove hemorrhoids and fiss	6.54		7.62	1	General Surgery
46262	Remove hemorrhoids and fist	6.77		8.01	1	General Surgery
46900	Destruction of anal lesion(s)	1.81			6	Refer to CPT
46945	Ligation of hemorrhoids	3.06		1.90	3	General Surgery

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Code	Descriptor	1995 RVU	RUC Rec RVU	Key	Topic
46946	Ligation of hemorrhoids	4.04	2.76	3	General Surgery
47130	Partial removal of liver	31.56	31.56	2	General Surgery
47425	Incision of bile duct	14.79		7	General Surgery
47600	Removal of gallbladder	10.68	10.68	2	General Surgery
47605	Removal of gallbladder	11.53	11.53	2	General Surgery
47610	Removal of gallbladder	13.86	15.00	1	General Surgery
48150	Partial removal of pancreas	40.25	40.25	2	General Surgery
49000	Exploration of abdomen	8.99	11.00	1	General Surgery
49020	Drain abdominal abscess	9.06		6	Refer to CPT
49180	Biopsy abdominal mass	1.49	1.73	4	General Surgery
49255	Removal of omentum	4.04	10.25	4	General Surgery
49505	Repair inguinal hernia	6.17	6.17	2	General Surgery
49605	Repair umbilical lesion	21.92	21.92	2	Potentially Overvalued Services
49606	Repair umbilical lesion	17.93	17.93	2	Potentially Overvalued Services
49900	Repair of abdominal wall	4.54	9.40	1	General Surgery
50010	Exploration of kidney	10.07	10.07	2	Urology
50020	Drainage of kidney abscess	12.41	12.41	2	Urology
50040	Drainage of kidney	13.80	13.80	2	Urology
50081	Removal of kidney stone	20.58	20.58	2	Urology
50200	Biopsy of kidney	2.63	2.63	2	Urology
50205	Biopsy of kidney	12.69	12.69	2	Urology
50220	Removal of kidney	15.98	15.98	2	Urology
50225	Removal of kidney	18.93	18.93	2	Urology
50230	Removal of kidney	20.56	20.56	2	Urology
50234	Removal of kidney and ureter	21.11	21.11	2	Urology
50236	Removal of kidney and ureter	23.33	23.33	2	Urology
50240	Partial removal of kidney	20.24	20.24	2	Urology
50320	Removal of donor kidney	21.22	21.22	2	Urology
50390	Drainage of kidney lesion	3.24	1.96	3	Urology
50392	Insert kidney drain	5.59	3.38	3	Urology

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
50393	Insert ureteral tube	6.88		4.16	3	Urology
50395	Create passage to kidney	5.15		3.38	3	Urology
50590	Fragmenting of kidney stone	9.62		9.62	2	Urology
50684	Injection for ureter x-ray	0.76		0.76	2	Urology
50715	Release of ureter	17.60		17.60	2	Urology
51010	Drainage of bladder	2.54		2.54	2	Urology
51597	Removal of pelvic structures	35.27		35.27	2	Urology
51600	Injection for bladder x-ray	0.88		0.88	2	Urology
51605	Preparation for bladder x-ray	1.13		0.64	3	Urology
51610	Injection for bladder x-ray	1.59		1.05	3	Urology
51700	Irrigation of bladder	0.88		0.88	2	Urology
51720	Treatment of bladder lesion	1.96		1.96	2	Urology
51725	Simple cystometrogram	1.51		1.51	2	Urology
51726	Complex cystometrogram	1.71		1.71	2	Urology
51736	Urine flow measurement	0.84		0.61	3	Urology
51741	Electro-uroflowmetry first	1.57		1.57	2	Urology
51772	Urethra pressure profile	1.61		1.61	2	Urology
51785	Anal/urinary muscle study	1.53		1.53	2	Urology
51792	Urinary reflex study	1.10		1.10	2	Urology
51795	Urine voiding pressure study	1.53		1.53	2	Urology
51797	Intraabdominal pressure test	1.60		1.60	2	Urology
52007	Cystoscopy and biopsy	3.02		3.02	2	Urology
52270	Cystoscopy and revise urethra	3.84		3.37	3	Urology
52275	Cystoscopy and revise urethra	4.70		4.70	2	Urology
52276	Cystoscopy and treatment	3.93		5.00	1	Urology
52277	Cystoscopy and treatment	6.17		6.17	2	Urology
52340	Cystoscopy and treatment	7.76			6	Refer to CPT
52500	Revision of bladder neck	7.82		7.82	2	Urology
52510	Dilation prostatic urethra	6.04		6.04	2	Urology
53600	Dilate urethra stricture	1.21			6	Refer to CPT

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53620	Dilate urethra stricture	1.62			6	Refer to CPT
53640	Relieve bladder retention	1.59			6	Refer to CPT
54100	Biopsy of penis	1.90			6	Refer to CPT
54200	Treatment of penis lesion	1.01		1.01	2	Urology
54231	Dynamic cavernosometry	2.04		2.04	2	Urology
54640	Suspension of testis	6.55		6.55	2	Urology
56300	Pelvic laparoscopy diagnostic	3.58			6	Refer to CPT
56305	Pelvic laparoscopy biopsy	3.80			6	Refer to CPT
56307	Laparoscopy remove adnexa	5.60		10.68	4	Gynecology
56309	Laparoscopy remove myoma	5.60		13.79	1	Gynecology
56312	Laparoscopic lymphadenecto	12.86		12.06	2	General Surgery
56315	Laparoscopic appendectomy	6.06		6.06	2	General Surgery
56340	Laparoscopic cholecystectomy	10.68		10.68	2	General Surgery
56341	Laparoscopic cholecystectomy	11.53		11.53	2	General Surgery
56360	Peritoneoscopy	4.04		3.87	3	General Surgery
56605	Biopsy of vulva/perineum	0.86		1.10	1	Gynecology
56606	Biopsy of vulva/perineum	0.43		0.55	1	Gynecology
56633	Extensive vulva surgery	12.15		15.00	4	Gynecology
57110	Removal of vagina	13.48		13.48	2	Gynecology
57150	Treat vagina infection	0.94		0.55	3	Gynecology
57265	Extensive repair of vagina	7.36		7.36	2	Gynecology
57270	Repair of bowel pouch	7.36		11.30	4	Gynecology
57280	Suspension of vagina	8.35		14.10	4	Gynecology
57289	Repair bladder and vagina	6.40		10.80	4	Gynecology
57305	Repair rectum-vagina fistula	8.69		12.75	4	Gynecology
57307	Fistula repair and colostomy	10.05		15.08	4	Gynecology
57400	Dilation of vagina	0.83		2.27	1	Gynecology
57410	Pelvic examination	0.59		1.75	1	Gynecology
57415	Removal vaginal foreign body	0.91		2.12	1	Gynecology
57540	Removal of residual cervix	6.01		11.54	4	Gynecology

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57545	Remove cervix repair pelvis	6.63		12.30	4	Gynecology
58120	Dilation and curettage (Dand	2.45		2.91	4	Gynecology
58140	Removal of uterus lesion	7.61		13.79	1	Gynecology
58150	Total hysterectomy	13.00		14.30	4	Gynecology
58180	Partial hysterectomy	9.06		14.30	4	Gynecology
58200	Extensive hysterectomy	20.34		20.34	2	Gynecology
58210	Extensive hysterectomy	23.97		27.50	4	Gynecology
58240	Removal of pelvis contents	28.79		35.27	4	Gynecology
58301	Remove intrauterine device	0.73		1.27	4	Gynecology
58323	Sperm washing	0.23		0.23	2	Gynecology
58410	Suspension of uterus	6.78		12.00	4	Gynecology
58520	Repair of ruptured uterus	6.35		11.11	1	Gynecology
58540	Revision of uterus	8.58		13.96	1	Gynecology
58720	Removal of ovary/tube(s)	6.20		10.68	4	Gynecology
58750	Repair oviduct(s)	8.82		14.26	4	Gynecology
58752	Revise ovarian tube(s)	7.94		14.26	4	Gynecology
58760	Remove tubal obstruction	7.16		12.50	4	Gynecology
58770	Create new tubal opening	6.96		13.34	1	Gynecology
58822	Drainage of ovarian abscess	6.18		9.06	4	Gynecology
58925	Removal of ovarian cyst(s)	6.40		10.68	4	Gynecology
58952	Resect ovarian malignancy	21.35		23.35	4	Gynecology
58960	Exploration of abdomen	10.14		13.66	4	Gynecology
59100	Remove uterus lesion	5.96		11.54	4	Gynecology
59120	Treat ectopic pregnancy	7.11		10.68	4	Gynecology
59121	Treat ectopic pregnancy	6.99		10.99	1	Gynecology
59130	Treat ectopic pregnancy	7.88		13.49	4	Gynecology
59136	Treat ectopic pregnancy	8.69		12.50	1	Gynecology
59841	Abortion	3.24		4.80	4	Gynecology
60225	Partial removal of thyroid	11.65		13.31	1	Otolaryngology
60240	Removal of thyroid	15.66		15.66	2	Otolaryngology

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60252	Removal of thyroid	15.40		17.23	1	Otolaryngology
60254	Extensive thyroid surgery	16.68		22.50	1	Otolaryngology
61020	Remove brain cavity fluid	1.51		1.51	2	Neurosurgery
61026	Injection into brain canal	1.69		1.69	2	Neurosurgery
61105	Drill skull for examination	8.19		4.82	3	Neurosurgery
61106	Drill skull for exam/surgery	7.35		4.62	3	Neurosurgery
61107	Drill skull for implantation	4.35		5.00	1	Neurosurgery
61108	Drill skull for drainage	10.80		9.00	3	Neurosurgery
61120	Pierce skull for examination	9.31		8.00	3	Neurosurgery
61210	Pierce skull implant device	4.72		5.84	1	Neurosurgery
61215	Insert brain-fluid device	10.05		4.00	3	Neurosurgery
61250	Pierce skull and explore	11.03		9.40	3	Neurosurgery
61253	Pierce skull and explore	13.00		11.27	3	Neurosurgery
61312	Open skull for drainage	20.54		21.83	1	Neurosurgery
61313	Open skull for drainage	20.54		22.50	1	Neurosurgery
61330	Decompress eye socket	15.65		21.55	1	Neurosurgery
61340	Relieve cranial pressure	11.56		17.33	1	Neurosurgery
61470	Incise skull for surgery	20.79		24.60	1	Neurosurgery
61480	Incise skull for surgery	16.77		25.03	1	Neurosurgery
61490	Incise skull for surgery	15.63		24.20	1	Neurosurgery
61510	Removal of brain lesion	23.39		26.77	1	Neurosurgery
61512	Remove brain lining lesion	24.26		33.51	1	Neurosurgery
61518	Removal of brain lesion	32.27		35.59	1	Neurosurgery
61519	Remove brain lining lesion	33.84		39.58	1	Neurosurgery
61520	Removal of brain lesion	38.35		52.98	1	Neurosurgery
61521	Removal of brain lesion	39.48		42.20	1	Neurosurgery
61526	Removal of brain lesion	29.71		50.59	1	Neurosurgery
61531	Implant brain electrodes	20.50		12.95	3	Neurosurgery
61533	Implant brain electrodes	23.41		18.05	3	Neurosurgery
61536	Removal of brain lesion	29.43		33.49	1	Neurosurgery

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
61538	Removal of brain tissue	28.05		25.09	3	Neurosurgery
61539	Removal of brain tissue	30.05		30.05	2	Neurosurgery
61542	Removal of brain tissue	27.39		29.05	1	Neurosurgery
61543	Removal of brain tissue	20.62		27.32	1	Neurosurgery
61545	Excision of brain tumor	34.50		41.76	1	Neurosurgery
61576	Skull base/brainstem surgery	33.82		50.08	1	Neurosurgery
61680	Intracranial vessel surgery	36.45		29.13	3	Neurosurgery
61682	Intracranial vessel surgery	42.21		59.47	1	Neurosurgery
61684	Intracranial vessel surgery	39.25		38.23	3	Neurosurgery
61686	Intracranial vessel surgery	47.45		62.08	1	Neurosurgery
61690	Intercranial vessel surgery	33.82		27.80	3	Neurosurgery
61692	Intracranial vessel surgery	37.96		49.74	1	Neurosurgery
61700	Inner skull vessel surgery	34.83		48.30	1	Neurosurgery
61702	Inner skull vessel surgery	39.20		46.31	1	Neurosurgery
61720	Incise skull/brain surgery	15.85		15.92	1	Neurosurgery
61735	Incise skull/brain surgery	17.08		18.72	1	Neurosurgery
61750	Incise skull brain biopsy	10.03		16.67	1	Neurosurgery
61751	Brain biopsy with cat scan	15.18		16.66	1	Neurosurgery
61760	Implant brain electrodes	24.83		21.00	3	Neurosurgery
61770	Incise skull for treatment	15.14		19.78	1	Neurosurgery
61791	Treat trigeminal tract	7.29		13.99	1	Neurosurgery
61793	Focus radiation beam	16.70		17.88	1	Neurosurgery
61850	Implant neuroelectrodes	15.98		11.50	3	Neurosurgery
61855	Implant neuroelectrodes	12.94		12.50	3	Neurosurgery
61860	Implant neuroelectrodes	11.20		19.60	1	Neurosurgery
61865	Implant neuroelectrodes	21.70		21.70	2	Neurosurgery
61870	Implant neuroelectrodes	5.77		13.67	1	Neurosurgery
61875	Implant neuroelectrodes	9.20		13.79	1	Neurosurgery
61885	Implant neuroreceiver	2.35		5.28	1	Neurosurgery
61888	Revise/remove neuroreceiver	3.10		4.67	1	Neurosurgery

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
62180	Establish brain cavity shunt	12.72		19.71	1	Neurosurgery
62194	Replace/irrigate catheter	2.81		4.50	1	Neurosurgery
62200	Establish brain cavity shunt	13.24		17.33	1	Neurosurgery
62201	Establish brain cavity shunt	12.10		13.54	1	Neurosurgery
62223	Establish brain cavity shunt	12.81		11.96	3	Neurosurgery
62268	Drain spinal cord cyst	3.87		4.74	1	Neurosurgery
62269	Needle biopsy spinal cord	4.07		5.02	1	Neurosurgery
62275	Inject spinal aneshtetic	1.79		1.79	2	Potentially Overvalued Services
62287	Percutaneous discectomy	4.13		7.43	1	Neurosurgery
62290	Inject for spine disk x-ray	3.58		3.00	3	Neurosurgery
62294	Injection into spinal artery	8.05		0.95	1	Neurosurgery
63005	Removal of spinal lamina	13.53		13.88	1	Neurosurgery
63011	Removal of spinal lamina	11.11		13.40	1	Neurosurgery
63015	Removal of spinal lamina	16.59		17.77	1	Neurosurgery
63017	Removal of spinal lamina	15.85		14.90	3	Neurosurgery
63020	Neck spine disk surgery	12.53		13.77	1	Neurosurgery
63030	Low back disk surgery	12.11		11.10	3	Neurosurgery
63042	Low back disk surgery	17.27		16.56	3	Neurosurgery
63047	Removal of spine lamina	12.76		13.57	1	Neurosurgery
63057	Decompress spinal cord	3.00		5.26	1	Neurosurgery
63075	Neck spine disk surgery	19.77		18.50	3	Neurosurgery
63087	Removal of vertebral body	27.56		33.91	1	Neurosurgery
63655	Implant neuroelectrodes	8.95		9.30	1	Neurosurgery
63740	Install spinal shunt	10.43		10.37	3	Neurosurgery
63741	Install spinal shunt	7.13		7.57	1	Neurosurgery
63744	Revision of spinal shunt	6.83		7.34	1	Neurosurgery
63750	Insert spinal canal catheter	7.23		7.81	1	Neurosurgery
64443	Injection for nerve block	1.35		0.98	3	Neurosurgery
64623	Inject treatment of nerve	0.99		0.99	2	Potentially Overvalued Services
64718	Revise ulnar nerve at elbow	5.48		5.48	2	Orthopaedic Surgery

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
64721	Carpal tunnel surgery	3.99		3.99	2	Orthopaedic Surgery
64734	Incision of cheek nerve	4.62		4.50	3	Otolaryngology
64736	Incision of chin nerve	4.40		4.40	2	Otolaryngology
65101	Removal of eye	6.52		6.52	2	Ophthalmology
65105	Remove eye attach implant	7.82			6	Refer to CPT
65205	Remove foreign body from ey	0.78		0.71	5	Ophthalmology
65430	Corneal smear	0.87		1.47	4	Ophthalmology
65450	Treatment of corneal lesion	3.07		3.07	2	Ophthalmology
65710	Corneal transplant	9.52		11.75	1	Ophthalmology
65730	Corneal transplant	11.83		13.50	1	Ophthalmology
65750	Corneal transplant	12.58		14.25	4	Ophthalmology
65755	Corneal transplant	12.58		14.25	4	Ophthalmology
65820	Relieve inner eye pressure	7.60		7.60	2	Ophthalmology
65855	Laser surgery of eye	4.65		4.15	3	Ophthalmology
66170	Implant eye shunt	11.31		11.26	3	Ophthalmology
66172	Implant eye shunt	13.67		13.62	3	Ophthalmology
66180	Implant eye shunt	12.63		14.00	1	Ophthalmology
66821	After cataract laser surgery	2.78		2.78	2	Ophthalmology
66825	Reposition intraocular lens	7.73		7.73	2	Ophthalmology
66830	Removal of lens lesion	7.80		7.80	2	Ophthalmology
66840	Removal of lens material	7.51		7.51	2	Ophthalmology
66850	Removal of lens material	8.66		8.66	2	Ophthalmology
66852	Removal of lens material	9.52		9.52	2	Ophthalmology
66920	Extraction of lens	8.46		8.46	2	Ophthalmology
66930	Extraction of lens	9.73		9.73	2	Ophthalmology
66940	Extraction of lens	8.48		8.48	2	Ophthalmology
66983	Remove cataract insert lens	8.54		8.54	2	Ophthalmology
66984	Remove cataract insert lens	9.89		9.89	2	Ophthalmology
66985	Insert lens prosthesis	7.89		7.89	2	Ophthalmology
66986	Exchange lens prosthesis	11.78		11.78	2	Ophthalmology

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
67005	Partial Removal of eye fluid	6.63		5.50	3	Ophthalmology
67015	Release of eye fluid	6.69		6.69	2	Ophthalmology
67210	Treatment of retinal lesion	9.48			6	Refer to CPT
67312	Revise two eye muscles	7.55		8.19	4	Ophthalmology
67316	Revise two eye muscles	8.02		9.26	4	Ophthalmology
67420	Orbitotomy with bone flap or	13.36		19.00	1	Ophthalmology
67900	Repair brow defect	4.54		5.84	1	Ophthalmology
67904	Repair eyelid defect	5.96		5.96	2	Ophthalmology
67911	Revise eyelid defect.	5.09		5.09	2	Ophthalmology
67924	Repair eyelid defect	5.64		5.64	2	Ophthalmology
67966	Excision and repair of eyelid	6.39		6.39	2	Ophthalmology
68720	Create tear sac drain	7.68		8.56	4	Ophthalmology
68745	Create tear duct drain	8.23		8.23	2	Ophthalmology
68750	Create tear duct drain	8.21		8.21	2	Ophthalmology
68825	Biopsy of tear sac	1.53			6	Refer to CPT
68830	Re-open tear duct channel	2.12		2.12	2	Ophthalmology
69100	Biopsy of external ear	0.76		0.81	1	Otolaryngology
69110	Partial removal external ear	3.34		3.34	2	Otolaryngology
69150	Extensive ear canal surgery	13.01		13.01	2	Otolaryngology
69155	Extensive ear/neck surgery	17.03		19.09	4	Otolaryngology
69320	Rebuild outer ear canal	16.60		16.60	2	Otolaryngology
69530	Extensive mastoid surgery	18.04		18.04	2	Otolaryngology
69535	Remove part of temporal bone	34.50		34.50	2	Otolaryngology
69554	Remove ear lesion	25.78		31.27	4	Otolaryngology
69605	Mastoid surgery revision	18.04		18.04	2	Otolaryngology
69660	Revise middle ear bone	11.64		11.64	2	Otolaryngology
69661	Revise middle ear bone	15.32		15.32	2	Otolaryngology
69662	Revise middle ear bone	15.04		15.04	2	Otolaryngology
69725	Release facial nerve	18.98		24.01	4	Otolaryngology
69805	Explore inner ear	10.27		13.18	4	Otolaryngology

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
69930	Implant cochlear device	14.00		16.13	4	Otolaryngology
69950	Incise inner ear nerve	21.15		24.21	4	Otolaryngology
69955	Release facial nerve	22.12		25.54	4	Otolaryngology
69960	Release inner ear canal	19.75		25.54	4	Otolaryngology
69970	Remove inner ear lesion	22.30		28.54	4	Otolaryngology
70030	X-ray eye for foreign body	0.17		0.17	2	Imaging
70100	X-ray exam of jaw	0.18		0.18	2	Imaging
70110	X-ray exam of jaw	0.25		0.25	2	Imaging
70120	X-ray exam of mastoids	0.18		0.18	2	Imaging
70130	X-ray exam of mastoids	0.34		0.34	2	Imaging
70140	X-ray exam of facial bones	0.19		0.19	2	Imaging
70150	X-ray exam of facial bones	0.26		0.26	2	Imaging
70160	X-ray exam of nasal bones	0.17		0.17	2	Imaging
70170	X-ray exam of tear duct	0.30		0.30	2	Imaging
70210	X-ray exam of sinuses	0.17		0.17	2	Imaging
70220	X-ray exam of sinuses	0.25		0.25	2	Imaging
70250	X-ray exam of skull	0.24		0.24	2	Imaging
70260	X-ray exam of skull	0.34		0.34	2	Imaging
70300	X-ray exam of teeth	0.10		0.10	2	Imaging
70310	X-ray exam of teeth	0.16		0.16	2	Imaging
70320	Full mouth x-ray of teeth	0.22		0.22	2	Imaging
70328	X-ray exam of jaw joint	0.18		0.18	2	Imaging
70330	X-ray exam of jaw joints	0.24		0.24	2	Imaging
70332	X-ray exam of jaw joint	0.54		0.54	2	Imaging
70336	Magnetic image jaw joint	0.95		1.48	1	Imaging
70350	X-ray head for orthodontia	0.17		0.17	2	Imaging
70355	Panoramic x-ray of jaws	0.20		0.20	2	Imaging
70360	X-ray exam of neck	0.17		0.17	2	Imaging
70380	X-ray exam of salivary gland	0.17		0.17	2	Imaging
70390	X-ray exam of salivary duct	0.38		0.38	2	Imaging

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
70450	CAT scan of head or brain	0.85		0.85	2	Imaging
70460	Contrast CAT scan of head	1.13		1.13	2	Imaging
70470	Contrast CAT scans of head	1.27		1.27	2	Imaging
70480	CAT scan of skull	1.28		1.28	2	Imaging
70481	Contrast CAT scan of skull	1.38		1.38	2	Imaging
70482	Contrast CAT scans of skull	1.45		1.45	2	Imaging
70486	CAT scan of face jaw	1.14		1.14	2	Imaging
70487	Contrast CAT scan face/jaw	1.30		1.30	2	Imaging
70488	Contrast CAT scans face/jaw	1.42		1.42	2	Imaging
70490	CAT scan of neck tissue	1.28		1.28	2	Imaging
70491	Contrast CAT of neck tissue	1.38		1.38	2	Imaging
70492	Contrast CAT of neck tissue	1.45		1.45	2	Imaging
70540	Magnetic image face neck	1.48		1.48	2	Imaging
70551	Magnetic image brain (MRI)	1.48		1.48	2	Imaging
70552	Magnetic image brain (MRI)	1.78		1.78	2	Imaging
70553	Magnetic image brain	2.36		2.36	2	Imaging
71010	Chest x-ray	0.18		0.18	2	Imaging
71015	X-ray exam of chest	0.21		0.21	2	Imaging
71020	Chest x-ray	0.22		0.22	2	Imaging
71021	Chest x-ray	0.27		0.27	2	Imaging
71022	Chest x-ray	0.31		0.31	2	Imaging
71035	Chest x-ray	0.18		0.18	2	Imaging
71040	Contrast x-ray of bronchi	0.58		0.58	2	Imaging
71060	Contrast x-ray of bronchi	0.74		0.74	2	Imaging
71100	X-ray exam of ribs	0.22		0.22	2	Imaging
71101	X-ray exam of ribs chest	0.27		0.27	2	Imaging
71110	X-ray exam of ribs	0.27		0.27	2	Imaging
71111	X-ray exam of ribs chest	0.32		0.32	2	Imaging
71120	X-ray exam of breastbone	0.20		0.20	2	Imaging
71130	X-ray exam of breastbone	0.22		0.22	2	Imaging

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
71250	Cat scan of chest	1.16		1.16	2	Imaging
71260	Contrast CAT scan of chest	1.24		1.24	2	Imaging
71270	Contrast CAT scans of chest	1.38		1.38	2	Imaging
71550	Magnetic image chest	1.60		1.60	2	Imaging
72020	X-ray exam of spine	0.15		0.15	2	Imaging
72040	X-ray exam of neck spine	0.22		0.22	2	Imaging
72050	X-ray exam of neck spine	0.31		0.31	2	Imaging
72069	X-ray exam of trunk spine	0.22		0.22	2	Imaging
72070	X-ray exam of thorax spine	0.22		0.22	2	Imaging
72072	X-ray exam of thoracic spine	0.22		0.22	2	Imaging
72074	X-ray exam of thoracic spine	0.22		0.22	2	Imaging
72080	X-ray exam of trunk spine	0.22		0.22	2	Imaging
72090	X-ray exam of trunk spine	0.28		0.28	2	Imaging
72100	X-ray exam of lower spine	0.22		0.22	2	Imaging
72110	X-ray exam of lower spine	0.31		0.31	2	Imaging
72114	X-ray exam of lower spine	0.36		0.36	2	Imaging
72120	X-ray exam of lower spine	0.22		0.22	2	Imaging
72125	CAT scan of neck spine	1.16		1.16	2	Imaging
72126	Contrast CAT scan of neck	1.22		1.22	2	Imaging
72127	Contrast CAT scans of neck	1.27		1.27	2	Imaging
72128	CAT scan of thorax spine	1.16		1.16	2	Imaging
72129	Contrast CAT scan of thorax	1.22		1.22	2	Imaging
72130	Contrast CAT scans of thorax	1.27		1.27	2	Imaging
72131	CAT scan of lower spine	1.16		1.16	2	Imaging
72132	Contrast CAT of lower spine	1.22		1.22	2	Imaging
72133	Contrast CAT scans low spine	1.27		1.27	2	Imaging
72141	Magnetic image neck spine	1.60		1.60	2	Imaging
72142	Magnetic image neck spine	1.92		1.92	2	Imaging
72146	Magnetic image chest spine	1.60		1.60	2	Imaging
72147	Magnetic image chest spine	1.92		1.92	2	Imaging

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
72148	Magnetic image lumbar spine	1.48		1.48	2	Imaging
72149	Magnetic image lumbar spine	1.78		1.78	2	Imaging
72156	Magnetic image neck spine	2.57		2.57	2	Imaging
72157	Magnetic image chest spine	2.57		2.57	2	Imaging
72158	Magnetic image lumbar spine	2.36		2.36	2	Imaging
72170	X-ray exam of pelvis	0.17		0.17	2	Imaging
72190	X-ray exam of pelvis	0.21		0.21	2	Imaging
72192	CAT scan of pelvis	1.09		1.09	2	Imaging
72193	Contrast CAT scan of pelvis	1.16		1.16	2	Imaging
72194	Contrast CAT scans of pelvis	1.22		1.22	2	Imaging
72196	Magnetic image pelvis	1.60		1.60	2	Imaging
72200	X-ray exam sacroiliac joints	0.17		0.17	2	Imaging
72202	X-ray exam sacroiliac joints	0.19		0.19	2	Imaging
72220	X-ray exam of tailbone	0.17		0.17	2	Imaging
72265	Contrast x-ray lower spine	0.83		0.83	2	Imaging
73000	X-ray exam of collarbone	0.16		0.16	2	Imaging
73010	X-ray exam of shoulder blade	0.17		0.17	2	Imaging
73020	X-ray exam of shoulder	0.15		0.15	2	Imaging
73030	X-ray exam of shoulder	0.18		0.18	2	Imaging
73040	Contrast x-ray of shoulder	0.54		0.54	2	Imaging
73050	X-ray exam of shoulders	0.20		0.20	2	Imaging
73060	X-ray exam of humerus	0.17		0.17	2	Imaging
73070	X-ray exam of elbow	0.15		0.15	2	Imaging
73080	X-ray exam of elbow	0.17		0.17	2	Imaging
73085	Contrast x-ray of elbow	0.54		0.54	2	Imaging
73090	X-ray exam of forearm	0.16		0.16	2	Imaging
73092	X-ray exam of arm infant	0.16		0.16	2	Imaging
73100	X-ray exam of wrist	0.16		0.16	2	Imaging
73110	X-ray exam of wrist	0.17		0.17	2	Imaging
73115	Contrast x-ray of wrist	0.54		0.54	2	Imaging

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Code	Descriptor	1995 RVU	RUC Rec	RVU	Key	Topic
73120	X-ray exam of hand	0.16		0.16	2	Imaging
73130	X-ray exam of hand	0.17		0.17	2	Imaging
73140	X-ray exam of finger(s)	0.13		0.13	2	Imaging
73200	CAT scan of arm	1.09		1.09	2	Imaging
73201	Contrast CAT scan of arm	1.16		1.16	2	Imaging
73202	Contrast CAT scans of arm	1.22		1.22	2	Imaging
73220	Magnetic image arm hand	1.48		1.48	2	Imaging
73221	Magnetic image joint of arm	0.95		1.48	1	Imaging
73225	Magnetic imaging/upper (MR	1.73		1.73	2	Imaging
73500	X-ray exam of hip	0.17		0.17	2	Imaging
73510	X-ray exam of hip	0.21		0.21	2	Imaging
73520	X-ray exam of hips	0.26		0.26	2	Imaging
73525	Contrast x-ray of hip	0.54		0.54	2	Imaging
73530	X-ray exam of hip	0.29		0.29	2	Imaging
73540	X-ray exam of pelvis and hips	0.20		0.20	2	Imaging
73550	X-ray exam of thigh	0.17		0.17	2	Imaging
73560	X-ray exam of knee	0.17		0.17	2	Imaging
73562	X-ray exam of knee	0.18		0.18	2	Imaging
73564	X-ray exam of knee	0.22		0.22	2	Imaging
73565	X-ray exam of knee	0.17		0.17	2	Imaging
73580	Contrast x-ray of knee joint	0.54		0.54	2	Imaging
73590	X-ray exam of lower leg	0.17		0.17	2	Imaging
73592	X-ray exam of leg infant	0.16		0.16	2	Imaging
73600	X-ray exam of ankle	0.16		0.16	2	Imaging
73610	X-ray exam of ankle	0.17		0.17	2	Imaging
73615	Contrast x-ray of ankle	0.54		0.54	2	Imaging
73620	X-ray exam of foot	0.16		0.16	2	Imaging
73630	X-ray exam of foot	0.17		0.17	2	Imaging
73650	X-ray exam of heel	0.16		0.16	2	Imaging
73660	X-ray exam of toe(s)	0.13		0.13	2	Imaging

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Code	Descriptor	1995 RVU	RUC Rec RVU	Key	Topic
73700	CAT scan of leg	1.09	1.09	2	Imaging
73701	Contrast CAT scan of leg	1.16	1.16	2	Imaging
73702	Contrast CAT scans of leg	1.22	1.22	2	Imaging
73720	Magnetic image leg foot	1.48	1.48	2	Imaging
73721	Magnetic image joint of leg	0.95	1.48	1	Imaging
74000	X-ray exam of abdomen	0.18	0.18	2	Imaging
74010	X-ray exam of abdomen	0.23	0.23	2	Imaging
74020	X-ray exam of abdomen	0.27	0.27	2	Imaging
74022	X-ray exam series abdomen	0.32	0.32	2	Imaging
74150	CAT scan of abdomen	1.19	1.19	2	Imaging
74160	Contrast CAT scan of abdome	1.27	1.27	2	Imaging
74170	Contrast CAT scans abdomen	1.40	1.40	2	Imaging
74181	Magnetic image abdomen (M	1.60	1.60	2	Imaging
74330	X-ray bile/pancreas endoscopy	0.70	0.90	1	Imaging
74360	X-ray guide, GI dilation	0.54	0.54	2	Potentially Overvalued Services
74710	X-ray measurement of pelvis	0.34	0.34	2	Imaging
75552	Magnetic image myocardium	1.60	1.60	2	Imaging
75553	Magnetic image myocardium	2.00	2.00	2	Imaging
75554	Cardiac MRI/function	1.83	1.83	2	Imaging
75555	Cardiac MRI/limited study	1.74	1.74	2	Imaging
75556	Cardiac MRI/flow mapping	0.00	0.00	2	Imaging
75630	X-ray aorta leg arteries	1.31	1.79	4	Imaging
76066	Joint(s) survey single film	0.31	0.31	2	Imaging
76090	Mammogram one breast	0.25	0.58	1	Imaging
76091	Mammogram both breasts	0.41	0.69	1	Imaging
76093	Magnetic image breast	1.63	1.63	2	Imaging
76094	Magnetic image both breasts	1.63	1.63	2	Imaging
76098	X-ray exam breast specimen	0.16	0.16	2	Imaging
76355	CAT scan for localization	1.21	1.21	2	Imaging
76360	CAT scan for needle biopsy	1.16	1.16	2	Imaging

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
76365	CAT scan for cyst aspiration	1.16		1.16	2	Imaging
76370	CAT scan for therapy guide	0.85		0.85	2	Imaging
76375	CAT scans other planes	0.16		0.16	2	Imaging
76380	CAT scan follow-up study	0.98		0.98	2	Imaging
76400	Magnetic image bone marrow	1.60		1.60	2	Imaging
76825	Echo exam of fetal heart	0.98		1.67	1	Imaging
77420	Weekly radiation therapy	1.61			7	Potentially Overvalued Services
77425	Weekly radiation therapy	2.44			7	Potentially Overvalued Services
77430	Weekly radiation therapy	3.60			7	Potentially Overvalued Services
77761	Radioelement application	3.56		3.56	2	Potentially Overvalued Services
78070	Parathyroid nuclear imaging	0.51		0.82	4	Imaging
78075	Adrenal nuclear imaging	0.74		0.74	2	Imaging
78195	Lymph system imaging	0.70		1.20	4	Imaging
78480	Heart function (add-on)	0.62			6	Refer to CPT
78635	CSF ventriculography	0.61		0.61	2	Imaging
78803	Tumor imaging (3D)	1.09		1.09	2	Potentially Overvalued Services
78805	Abcess imaging, ltd. area	0.73		0.73	2	Imaging
78806	Abcess imaging, whole body	0.73		0.73	2	Imaging
83020	Assay hemoglobin	0.37		0.37	2	Pathology
83912	Genetic examination	0.37		0.37	2	Pathology
84165	Assay serum proteins	0.37		0.37	2	Pathology
84181	Western blot test	0.37		0.37	2	Pathology
84182	Protein western blot test	0.37		0.37	2	Pathology
85095	Bone marrow aspiration	1.08		1.08	2	Pathology
85102	Bone marrow biopsy	1.37		1.37	2	Pathology
85390	Fibrinolysin screen	0.37		0.75	4	Pathology
85576	Blood platelet aggregation	0.37		0.37	2	Pathology
86077	Physician blood bank service	0.37		0.94	4	Pathology
86079	Physician blood bank service	0.37		0.94	1	Pathology
86255	Fluorescent antibody; screen	0.37		0.37	2	Pathology

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
86256	Fluorescent antibody; titer	0.37		0.37	2	Pathology
86320	Serum immunoelectrophor-esi	0.37		0.37	2	Pathology
86325	Other immunoelectrophor-esis	0.37		0.37	2	Pathology
86327	Immunoelectrophoresis assay	0.37		0.45	4	Pathology
86334	Immunofixation procedure	0.37		0.37	2	Pathology
88170	Fine needle aspiration	0.50		1.27	1	Pathology
88171	Fine needle aspiration	1.05		1.27	1	Pathology
88172	Evaluation of smear	0.60		0.60	2	Pathology
88173	Interpretation of smear	1.08		1.08	2	Pathology
88180	Cell marker study	0.36		0.36	2	Pathology
88182	Cell marker study	0.77		0.77	2	Pathology
88311	Decalcify tissue	0.24		0.24	2	Pathology
89060	Exam synovial fluid crystals	0.37		0.37	2	Pathology
90801	Psychiatric interview	2.19		2.80	1	Psychiatry
90820	Diagnostic interview	2.25		2.25	2	Psychiatry
90825	Evaluation of tests/records	0.97		0.97	2	Psychiatry
90835	Special interview	2.82		2.82	2	Psychiatry
90842	Psychotherapy 75-80 min	2.74		2.74	2	Psychiatry
90843	Psychotherapy 20-30 min	1.10		1.47	1	Psychiatry
90844	Psychotherapy 45-50 min	1.72		2.00	1	Psychiatry
90845	Medical psychoanalysis	1.78		1.78	2	Psychiatry
90846	Special family therapy	1.82		1.82	2	Psychiatry
90847	Special family therapy	2.19		2.19	2	Psychiatry
90853	Special group therapy	0.43		0.59	1	Psychiatry
90855	Individual psychotherapy	1.81		2.15	1	Psychiatry
90857	Special group therapy	0.43		0.43	2	Psychiatry
90862	Medication management	0.95		0.95	2	Psychiatry
90870	Electroconvulsive therapy	1.88		1.88	2	Psychiatry
90871	Electroconvulsive therapy	2.72		2.72	2	Psychiatry
90880	Medical hypnotherapy	2.19		2.19	2	Psychiatry

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
90887	Consultation with family	1.48		1.48	2	Psychiatry
90900	Biofeedback electromyogram	0.89		0.89	2	Other Medical and Therapeutic
90902	Biofeedback nerve impulse	0.89		0.43	3	Other Medical and Therapeutic
90904	Biofeedback blood pressure	0.89		0.43	3	Other Medical and Therapeutic
90906	Biofeedback blood flow	0.89		0.43	3	Other Medical and Therapeutic
90908	Biofeedback brain waves	0.89		0.43	3	Other Medical and Therapeutic
90910	Biofeedback oculogram	0.89		0.43	3	Other Medical and Therapeutic
90911	Anorectal biofeedback	2.15		2.15	2	Other Medical and Therapeutic
90915	Biofeedback unspecified	0.89		0.89	2	Other Medical and Therapeutic
91000	Esophageal intubation	0.99		0.73	3	Other Medical and Therapeutic
91010	Esophagus motility study	1.65		1.25	3	Other Medical and Therapeutic
91011	Esophagus motility study	1.98		1.50	3	Other Medical and Therapeutic
91012	Esophagus motility study	1.92		1.46	3	Other Medical and Therapeutic
91020	Esophagogastric study	1.89		1.44	3	Other Medical and Therapeutic
91030	Acid perfusion of the esophag	1.20		0.91	3	Other Medical and Therapeutic
91032	Esophagus acid reflux test	1.59		1.21	3	Other Medical and Therapeutic
91033	Prolonged acid reflux test	1.71		1.30	3	Other Medical and Therapeutic
91052	Gastric analysis test	1.71		0.79	3	Other Medical and Therapeutic
91055	Gastric intubation for smear	1.28		0.94	3	Other Medical and Therapeutic
91065	Breath hydrogen test	0.45		0.20	3	Other Medical and Therapeutic
91122	Anorectal manometry	1.77		1.77	2	General Surgery
92002	Eye exam new patient	1.01		0.79	3	Evaluation and Management
92004	Eye exam new patient	1.61		1.50	3	Evaluation and Management
92012	Eye exam established pt	0.82		0.80	3	Evaluation and Management
92014	Eye exam and treatment	1.06		1.27	1	Evaluation and Management
92018	New eye exam and treatment	1.51		1.51	2	Ophthalmology
92019	Eye exam and treatment	1.31		1.31	2	Ophthalmology
92020	Special eye evaluation	0.37		0.37	2	Ophthalmology
92060	Special eye evaluation	0.50		0.69	4	Ophthalmology
92070	Fitting of contact lens	0.70		0.70	2	Ophthalmology

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
92225	Special eye exam initial	0.58			6	Refer to CPT
92226	Special eye exam subsequent	0.50			6	Refer to CPT
92260	Ophthalmoscopy/dynamometr	0.50			6	Refer to CPT
92275	Electroretinography	1.01		1.01	2	Ophthalmology
92283	Color vision examination	0.26		0.17	3	Ophthalmology
92284	Dark adaptation eye exam	0.37		0.24	3	Ophthalmology
92506	Speech and hearing evaluatio	0.86		0.86	2	Speech/Hearing/Launguage
92507	Speech/hearing therapy	0.52		0.52	2	Speech/Hearing/Launguage
92508	Speech/hearing therapy	0.26		0.26	2	Speech/Hearing/Launguage
92512	Nasal function studies	0.55		0.55	2	Speech/Hearing/Launguage
92541	Spontaneous nystagmus test	0.40		0.40	2	Speech/Hearing/Launguage
92542	Positional nystagmus test	0.33		0.33	2	Speech/Hearing/Launguage
92543	Caloric vestibular test	0.38		0.38	2	Speech/Hearing/Launguage
92544	Optokinetic nystagmus test	0.26		0.26	2	Speech/Hearing/Launguage
92545	Oscillating tracking test	0.23		0.23	2	Speech/Hearing/Launguage
92546	Torsion swing recording	0.29		0.29	2	Speech/Hearing/Launguage
92585	Brainstem evoked audiometry	0.50		0.50	2	Speech/Hearing/Launguage
93000	Electrocardiogram complete	0.17		0.17	2	Cardiology/Interventional Radiology
93010	Electrocardiogram report	0.17		0.17	2	Cardiology/Interventional Radiology
93278	ECG/signal-averaged	0.35		0.25	3	Cardiology/Interventional Radiology
93307	Echo exam of heart	0.78		1.06	4	Cardiology/Interventional Radiology
93312	Echo exam of heart	1.57		2.39	1	Cardiology/Interventional Radiology
93320	Doppler echo exam heart	0.38		0.38	2	Cardiology/Interventional Radiology
93503	Insert/place heart catheter	2.43		2.43	2	Cardiology/Interventional Radiology
93505	Biopsy of heart lining	4.56		4.38	3	Cardiology/Interventional Radiology
93510	Left heart catheterization	4.33		4.33	2	Potentially Overvalued Services
93526	Rt and lt heart catheters	5.99		5.99	2	Potentially Overvalued Services
93527	Rt and Lt heart catheters	7.28		7.28	2	Cardiology/Interventional Radiology
93529	Rt Lt heart catheterization	4.80		4.80	2	Cardiology/Interventional Radiology
93539	Injection cardiac cath	0.29		0.40	1	Cardiology/Interventional Radiology

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
93544	Injection for aortography	0.29		0.25	3	Cardiology/Interventional Radiology
93545	Injection for coronary x-rays	0.29		0.40	1	Cardiology/Interventional Radiology
93561	Cardiac output measurement	1.15		0.50	3	Cardiology/Interventional Radiology
93562	Cardiac output measurement	0.37		0.16	3	Cardiology/Interventional Radiology
93621	Electrophysiology evaluation	12.66			6	Refer to CPT
93641	Electrophysiology evaluation	5.93		5.93	2	Cardiology/Interventional Radiology
93733	Telephone analysis pacemaker	0.17		0.17	2	Cardiology/Interventional Radiology
93875	Extracranial study	0.22		0.22	2	Cardiology/Interventional Radiology
93880	Extracranial study	0.60		0.60	2	Cardiology/Interventional Radiology
93882	Extracranial study	0.40		0.40	2	Cardiology/Interventional Radiology
93922	Extremity study	0.25		0.25	2	Cardiology/Interventional Radiology
93923	Extremity study	0.45		0.45	2	Cardiology/Interventional Radiology
93924	Extremity study	0.50		0.50	2	Cardiology/Interventional Radiology
93925	Lower extremity study	0.58		0.58	2	Cardiology/Interventional Radiology
93926	Lower extremity study	0.39		0.39	2	Cardiology/Interventional Radiology
93930	Upper extremity study	0.46		0.46	2	Cardiology/Interventional Radiology
93931	Upper extremity study	0.31		0.31	2	Cardiology/Interventional Radiology
93965	Extremity study	0.35		0.35	2	Cardiology/Interventional Radiology
93970	Extremity study	0.68		0.68	2	Cardiology/Interventional Radiology
93971	Extremity study	0.45		0.45	2	Cardiology/Interventional Radiology
93980	Penile vascular study	1.82		1.25	3	Cardiology/Interventional Radiology
93981	Penile vascular study	0.64		0.44	3	Cardiology/Interventional Radiology
94060	Evaluation of wheezing	0.31		0.31	2	Other Medical and Therapeutic
94150	Vital capacity test	0.11			6	Refer to CPT
94160	Vital capacity screening	0.18		0.18	2	Other Medical and Therapeutic
94240	Residual lung capacity	0.26		0.26	2	Other Medical and Therapeutic
94350	Lung nitrogen washout curve	0.26		0.26	2	Other Medical and Therapeutic
94360	Measure airflow resistance	0.26		0.26	2	Other Medical and Therapeutic
94375	Respiratory flow volume loop	0.31		0.31	2	Other Medical and Therapeutic
94400	CO2 breathing response curve	0.40		0.40	2	Potentially Overvalued Services

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
94720	Monoxide diffusing capacity	0.26		0.26	2	Other Medical and Therapeutic
94725	Membrane diffusion capacity	0.26		0.26	2	Other Medical and Therapeutic
94770	Exhaled carbon dioxide test	0.20		0.15	3	Other Medical and Therapeutic
95010	Sensitivity skin tests	0.15		0.15	2	Other Medical and Therapeutic
95015	Sensitivity skin test	0.15		0.15	2	Other Medical and Therapeutic
95075	Ingestion challenge test	0.95		0.95	2	Other Medical and Therapeutic
95851	Range of motion measuremen	0.28		0.16	3	Other Medical and Therapeutic
95852	Range of motion measuremen	0.19		0.11	3	Other Medical and Therapeutic
95867	Muscle test head or neck	0.62		0.79	1	Other Medical and Therapeutic
95868	Muscle test head or neck	1.50		1.18	3	Other Medical and Therapeutic
95872	Muscle test one fiber	1.50			6	Refer to CPT
95937	Neuromuscular junction test	0.60		0.65	1	Other Medical and Therapeutic
95951	EEG monitoring/video-record	3.80		6.00	1	Other Medical and Therapeutic
96405	Intralesional chemo admin	0.52		0.52	2	Other Medical and Therapeutic
96406	Intralesional chemo admin	0.80		0.80	2	Other Medical and Therapeutic
96440	Chemotherapy intracavitary	2.37		2.37	2	Other Medical and Therapeutic
96445	Chemotherapy intracavitary	2.20		2.20	2	Other Medical and Therapeutic
96450	Chemotherapy into CNS	1.89		1.89	2	Other Medical and Therapeutic
97250	Myofascial release	0.45			6	Refer to CPT
97260	Regional manipulation	0.19			6	Refer to CPT
97261	Supplemental manipulation	0.12			6	Refer to CPT
97500	Orthotics training	0.31			6	Refer to CPT
97501	Supplemental training	0.17			6	Refer to CPT
97520	Prosthetic training;	0.37			6	Refer to CPT
97521	Supplemental training	0.22			6	Refer to CPT
98925	Osteopathic manipulation	0.45		0.45	2	Other Medical and Therapeutic
98926	Osteopathic manipulation	0.65		0.65	2	Other Medical and Therapeutic
98927	Osteopathic manipulation	0.87		0.87	2	Other Medical and Therapeutic
98928	Osteopathic manipulation	1.03		1.03	2	Other Medical and Therapeutic
98929	Osteopathic manipulation	1.19		1.19	2	Other Medical and Therapeutic

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
99201	Office/outpatient visit new	0.38		0.39	1	Evaluation and Management
99202	Office/outpatient visit new	0.75		0.79	1	Evaluation and Management
99203	Office/outpatient visit new	1.14		1.20	1	Evaluation and Management
99204	Office/outpatient visit new	1.71		1.80	1	Evaluation and Management
99205	Office/outpatient visit new	2.28		2.41	1	Evaluation and Management
99211	Office/outpatient visit est	0.17		0.25	1	Evaluation and Management
99212	Office/outpatient visit est	0.38		0.50	1	Evaluation and Management
99213	Office/outpatient visit est	0.55		0.80	1	Evaluation and Management
99214	Office/outpatient visit est	0.94		1.27	1	Evaluation and Management
99215	Office/outpatient visit est	1.51		1.90	1	Evaluation and Management
99221	Initial hospital care	1.06		1.06	2	Evaluation and Management
99222	Initial hospital care	1.84		1.84	2	Evaluation and Management
99223	Initial hospital care	2.57		2.57	2	Evaluation and Management
99231	Subsequent hospital care	0.51		0.65	4	Evaluation and Management
99232	Subsequent hospital care	0.88		1.30	4	Evaluation and Management
99233	Subsequent hospital care	1.25		1.75	4	Evaluation and Management
99238	Hospital discharge day	1.06			6	Refer to CPT
99241	Office consultation	0.54		0.63	4	Evaluation and Management
99242	Office consultation	1.11		1.25	4	Evaluation and Management
99243	Office consultation	1.47		1.90	4	Evaluation and Management
99244	Office consultation	2.23		2.50	4	Evaluation and Management
99245	Office consultation	2.96		3.21	4	Evaluation and Management
99251	Initial inpatient consult	0.54		0.63	4	Evaluation and Management
99252	Initial inpatient consult	1.13		1.25	4	Evaluation and Management
99253	Initial inpatient consult	1.56		1.90	4	Evaluation and Management
99254	Initial inpatient consult	2.27		2.50	4	Evaluation and Management
99255	Initial inpatient consult	3.14		3.40	4	Evaluation and Management
99261	Follow-up inpatient consult	0.36		0.65	4	Evaluation and Management
99262	Follow-up inpatient consult	0.74		1.30	4	Evaluation and Management
99263	Follow-up inpatient consult	1.16		1.75	4	Evaluation and Management

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Code	Descriptor	1995 RVU	RUC	Rec RVU	Key	Topic
99284	Emergency dept visit	1.68		1.68	2	Evaluation and Management
99285	Emergency dept visit	2.63		2.63	2	Evaluation and Management
99291	Critical care first hour	3.64		4.00	1	Evaluation and Management
99292	Critical care addl 30 min	1.84		2.00	1	Evaluation and Management
99301	Nursing facility care	1.07			6	Refer to CPT
99302	Nursing facility care	1.67			6	Refer to CPT
99303	Nursing facility care	2.29			6	Refer to CPT
99311	Nursing facility care subseque	0.54			6	Refer to CPT
99312	Nursing facility care subseque	0.89			6	Refer to CPT
99313	Nursing facility care subseque	1.19			6	Refer to CPT
99341	Home visit new patient	1.12		1.12	2	Evaluation and Management
99342	Home visit new patient	1.58		1.58	2	Evaluation and Management
99343	Home visit new patient	2.09		2.09	2	Evaluation and Management
99351	Home visit estab patient	0.83		0.83	2	Evaluation and Management
99352	Home visit estab patient	1.12		1.12	2	Evaluation and Management
99353	Home visit estab patient	1.48		1.48	2	Evaluation and Management
A2000	Chiropractor manipulation of	0.45			6	Refer to CPT
M0101	Cutting or removal of corns	0.37		0.45	4	Podiatry

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QUESTIONNAIRE

CPT Code Number: _____

Global Period: _____

CPT Descriptor: _____

Typical Service/Patient: _____

Step 1 Estimate the Relative Value of Physician Work (work RVU): _____

Step 2 List one or two important reference services (Table 1) in estimating physician work for this code (List only the CPT code numbers for the reference services):

1) _____ 2) _____

Step 3 Estimate the following service characteristics for the code that you have rated and your key reference services:

Service Characteristic	CPT code that you have rated in Step 1	Reference Service 1 (from Step 2)	Reference Service 2 (from Step 2)
CPT Code			
TIME IN MINUTES (See Appendix A for detailed definitions of Time Periods)			
Pre-Service Time			
Intra-Service Time			
Post-Service Time:			
Day of Procedure			
ICU (Total Time/Number of Visits)	/	/	/
Other Hospital (Total Time/# of Visits)	/	/	/
Office (Total Time/Number of Visits)	/	/	/
Complexity/Intensity on a scale of 1 to 5 (1=least complex, 5=most complex) (See Appendix A for detailed definitions)			
Mental Effort and Judgment			
Technical Skill & Physical Effort			
Psychological Stress			

Step 4 Has the work of performing this service changed in the past 5 years? ___ Yes ___ No. If yes, complete a - c.

a. This service represents new technology that has become more familiar (i.e., less work). ___ I agree ___ I do not agree
 b. Patients requiring this service are now: ___ more complex (more work) ___ less complex (less work) ___ no change
 c. The usual site-of-service has changed: ___ from outpatient to inpatient ___ from inpatient to outpatient ___ no change

Step 5 Do you agree that the Typical Service/Patient provided above describes your typical patient? Yes ___ No ___

CPT Code	1995 Descriptor	1995 Work RVU	Global Period
Table 1			
4/6/95			
Colon and Rectal Surgery			
American Society of Colon and Rectal Surgeons			
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	0.55	XXX
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	0.96	000
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	1.01	000
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient(s) and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.	1.11	XXX
46050	Incision and drainage, perianal abscess, superficial	1.14	010
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	1.26	000
46604	Anoscopy; with dilation, any method	1.31	000
46221	Hemorrhoidectomy, by simple ligature (eg, rubber band)	1.38	010
46500	Injection of sclerosing solution, hemorrhoids	1.53	010

American Society of Colon and Rectal Surgeons 1

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CPT Code	1995 Descriptor	1995 Work RVU	Global Period
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.	1.71	XXX
91122	Anorectal manometry	1.77	000
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	1.96	000
44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.82	000
46200	Fissurectomy, with or without sphincterotomy	3.02	090
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.70	000
46934	Destruction of hemorrhoids, any method; internal	3.84	090
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	4.01	000
46040	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	4.90	090
46255	Hemorrhoidectomy, internal and external, simple;	4.95	090
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	5.31	000
46280	Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton	5.63	090
45383	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	5.87	000

American Society of Colon and Rectal Surgeons 2

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CPT Code	1995 Descriptor	1995 Work RVU	Global Period
44950	Appendectomy;	6.06	090
46700	Anoplasty, plastic operation for stricture; adult	6.40	090
46260	Hemorrhoidectomy, internal and external, complex or extensive;	6.70	090
45170	Excision of rectal tumor, transanal approach	9.40	090
49560	Repair initial incisional hernia; reducible	9.48	090
45130	Excision of rectal procidentia, with anastomosis; perineal approach	13.03	090
44120	Enterectomy, resection of small intestine; single resection and anastomosis	13.15	090
44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)	15.00	090
44150	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy	19.04	090
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)	21.29	090
44153	Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy	24.69	090

CPT five-digit codes, two-digit number modifiers, and descriptions only are copyright by the American Medical Association. No payment schedules, fee schedules, relative value units, scales, conversion factors, or components thereof are included in CPT. The AMA is not recommending that any specific relative values, fees, payment schedules, or related listings be attached to CPT. Any relative value scales or relative listings assigned to CPT codes are not those of the AMA, and the AMA is not recommending use of these relative values.

File: FivYrRef

Appendix A
Components of Physicians' Total Work
MAJOR SURGERY
(090 Global Period)

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specialty and specific service. Your specialty may have developed a more specific listing of potential services within each component. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

- Time it takes to perform the service.
- Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill required with respect to knowledge, training and actual experience necessary to perform the service. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.
- Psychological stress - Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor" the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

PRE-SERVICE PERIOD Before the Service, <u>May Include</u>	INTRA-SERVICE PERIOD Work <u>During</u> the Service Is	POST-SERVICE PERIOD After the Service, <u>May Include</u>
<p><u>Services provided from the day before the surgery until the time of the procedure:</u></p> <p>Hospital admission work-up.</p> <p>The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.</p> <p>Other pre-operative work may include dressing, scrubbing, and waiting before surgery, preparing patient and needed equipment for surgery, positioning the patient and other non "skin-to-skin" work in the OR.</p> <p><u>Excludes:</u></p> <ul style="list-style-type: none"> • Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57). • Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25). 	<p><u>Work while you perform the service -- "skin-to-skin" work</u> including all intra-service activity that is normally included as a necessary part of the procedure.</p>	<p><u>Services provided within 90 days of the operation:</u></p> <p><u>Day of Procedure:</u></p> <p>Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits.</p> <p>Patient stabilization in the recovery room or special unit.</p> <p><u>Other follow-up care before the patient is discharged, if applicable:</u></p> <p>Post-operative visits, both in-hospital, if applicable, and out-patient office visits within 90 days of the operation</p> <p><u>Excludes:</u> Unrelated evaluation and management service provided during the postoperative period (reported with modifier -24)</p>

Appendix A
Components of Physicians' Total Work
MINOR SURGERY AND ENDOSCOPIES
(000 and 010 Global Period)

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specialty and specific service. Your specialty may have developed a more specific listing of potential services within each component. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

- Time it takes to perform the service.
- Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill required with respect to knowledge, training and actual experience necessary to perform the service. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.
- Psychological stress - Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor" the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

PRE-SERVICE PERIOD Before the Service, <u>May Include</u>	INTRA-SERVICE PERIOD Work <u>During</u> the Service Is	POST-SERVICE PERIOD After the Service, <u>May Include</u>
<p><u>Services provided from the day before the surgery until the time of the procedure:</u></p> <p>Hospital admission work-up.</p> <p>The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.</p> <p>Other pre-operative work may include dressing, scrubbing, and waiting before surgery, preparing patient and needed equipment for surgery, positioning the patient and other non "skin-to-skin" work in the OR.</p> <p>Excludes:</p> <ul style="list-style-type: none"> ● Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57). ● Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25). 	<p><u>Work while you perform the service</u> - "skin-to-skin" work including all intra-service activity that is normally included as a necessary part of the procedure.</p>	<p><u>Day of Procedure:</u></p> <p>Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits.</p> <p>Patient stabilization in the recovery room or special unit.</p> <p><u>Other follow-up care before the patient is discharged, if applicable:</u></p> <p>Post-procedure visits on the day of the procedure (global period = 000) or within 10 days of the procedure (global period = 010)</p> <p><u>Excludes:</u> Unrelated evaluation & management service provided during the postoperative period (reported with modifier -24)</p>

Appendix A

Components of Physicians' Total Work

EVALUATION AND MANAGEMENT SERVICES

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specialty and specific service. Your specialty may have developed a more specific listing of potential services within each component. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

- Time it takes to perform the service.
- Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill required with respect to knowledge, training and actual experience necessary to perform the service. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.
- Psychological stress - Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor" the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

	PRE-SERVICE PERIOD Before the Service, <u>May</u> Include	INTRA-SERVICE PERIOD Work <u>During</u> the Service Is	POST-SERVICE PERIOD After the Service, <u>May</u> Include
Office	<u>Preparing to see patient.</u> <u>Reviewing records.</u> <u>Communicating with other professionals.</u>	<u>Work while you are with the patient and/or family.</u> This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.	<u>Arranging for further services.</u> <u>Reviewing results of studies.</u> <u>Communicating further with patient, family, and other professionals, including written and telephone reports.</u>
Hospital	<u>Work while not present on the patient's hospital unit or floor, including:</u> Communicating further with other professionals and the patient's family. Obtaining and/or reviewing the results of diagnostic and other studies. Written and telephone reports.	<u>Work while you are present on the patient's hospital unit or floor, including:</u> Reviewing the patient's chart. Seeing the patient. Writing notes. Communicating with other professionals and the patient's family	<u>Work while not present on the patient's hospital unit or floor, including:</u> Communicating further with other professionals and the patient's family. Obtaining and/or reviewing the results of diagnostic and other studies. Written and telephone reports.

Appendix A

Components of Physicians' Total Work

EMERGENCY MEDICINE

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specialty and specific service. Your specialty may have developed a more specific listing of potential services within each component. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

- Time it takes to perform the service.
- Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill required with respect to knowledge, training and actual experience necessary to perform the service. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.
- Psychological stress - Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor" the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

	PRE-SERVICE PERIOD Before the Service, <u>May</u> Include	INTRA-SERVICE PERIOD Work During the Service Is	POST-SERVICE PERIOD After the Service, <u>May</u> Include
Invasive		Work for the total service period may include: <u>Reviewing records, obtaining and interpreting test results or X-rays, and preparing to perform the service.</u> <u>Performing the service.</u> <u>Providing immediate postprocedural care before the patient is discharged or admitted to the hospital.</u> <u>Communicating with the patient, patient's family, and/or other professionals.</u> <u>Completing charts.</u>	
Evaluation/ Management		Work for the total service may include: <u>Reviewing records, obtaining and interpreting test results or X-rays, and preparing to perform the service.</u> <u>Seeing the patient.</u> <u>Communicating with the patient, patient's family, and/or other professionals.</u> <u>Completing charts.</u>	

Appendix A

Components of Physicians' Total Work

LABORATORY/IMAGING/OTHER NON-EVALUATION AND MANAGEMENT SERVICES

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specialty and specific service. Your specialty may have developed a more specific listing of potential services within each component. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

- Time it takes to perform the service.
- Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill required with respect to knowledge, training and actual experience necessary to perform the service. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.
- Psychological stress - Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor" the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

PRE-SERVICE PERIOD Before the Service, <u>May</u> Include:	INTRA-SERVICE PERIOD Work During the Service Is	POST-SERVICE PERIOD After the Service, <u>May</u> Include
For these services, the service period is treated as a whole and includes the work from the time you begin the service until you complete it and report your results, if applicable. Consider only the work that you do and not work done by technicians or other professionals. Do not include distinct evaluation and management services provided in addition to procedure in your estimate.		

SPECIALTY SPECIFIC DESCRIPTIONS

PRE-SERVICE PERIOD Before the Service, <u>May</u> Include:	INTRA-SERVICE PERIOD Work During the Service Is	POST-SERVICE PERIOD After the Service, <u>May</u> Include

FIVE-YEAR REVIEW MULTIDISCIPLINARY WORKGROUPS

<u>GROUPS</u>	<u>ASSIGNED TOPICS</u>	<u>SPECIALTY OF MEMBER</u>
<u>Group 1</u> Tracy R. Gordy, MD* William Rich, MD Neil Powe, MD Charles Mabry, MD	Neurosurgery Nursing/Home Visits Anesthesiology	Psychiatry Ophthalmology Internal Med Gen Surgery
<u>Group 2</u> L. Charles Novak, MD* W. Benson Harer, MD Alan Morris, MD Clay Molstad, MD	Psychiatry Card/Int Rad ER/Critical Care Other Med/Ther	Anesthesiology Ob/Gynecology Orthopaedics Internal Med
<u>Group 3</u> James Moorefield, MD* Eugene Weiner, MD J. L. Lichtenfeld, MD	Urology Ob/Gynecology Hosp Visits	Radiology Pediatric Surgery Internal Med
<u>Group 4</u> George F. Kwass, MD* James G. Hoehn, MD Kay K. Hanley, MD Meghan Gerety, MD	Card/Thor/Vasc Gastro/General Surgery	Pathology Plastic Surgery Pediatrics Geriatrics
<u>Group 5</u> James E. Hayes, MD* William Gee, MD John Tudor, Jr., MD	Speech/Lan/Hear Office Visits Imaging Lab/Pathology	Emergency Med Urology Family Practice
<u>Group 6</u> Ray E. Stowers, DO* Timothy J. Gardner, MD C. Schmidt, Jr., MD Walter L. Larimore, MD	Integumentary Ophthalmology	Osteopathic Med Cardiac Surg Psychiatry Family Practice
<u>Group 7</u> David L. McCaffree, MD* Michael D. Maves, MD James Fanale, MD	Orthopaedic Surg Podiatric Med	Otolaryngology Geriatrics
<u>Group 8</u> William L. Winters, MD* Robert Florin, MD John O. Gage, MD Richard Tuck, MD	Head/Neck/Ear/ Maxillofacial	Cardiology Neurosurgery General Surg Pediatrics

* indicates workgroup chair

KEY TO THE DATA REPORTS

Behind the specialty recommendation form for each code is a 2-page report assembling the following data for each code:

- Data from the HCFA-supplied tables for all the public and carrier medical director comments, including: 1995 RVUs and their source; the commenter's recommended RVUs; the ratio of the recommended to the 1995 RVUs; the frequency of claims for the service; and, the reference services identified by the commenter. For CMD comments, this report also includes the actual CMD comment.
- An AMA analysis of Medicare claims data provides substantial information about each service, including: beneficiary age and other characteristics; recent trends in claims frequency and site of service; specialties that provide the service; and, diagnosis codes reported on claims.
- Each code was also analyzed to assess: (1) any changes in RVUs for each service during the first four years of RBRVS implementation; (2) how the 1995 Medicare RVUs compare to the final RVUs from Phase IV of the Harvard RBRVS study; and (3) all the available data from the Harvard study on each code, including pre-, intra-, and post-service times, number and type of post-service visits, and the ratio of intra-service work to intra-service time.

Most of this information is labelled in a manner that makes it easy to understand. The last page of this KEY explains the AMA analysis, which is listed in the data reports in the boxes labelled Beneficiary Information, Frequency, Site of Service, Specialty Mix, and Claims-Level Diagnosis Information. The following documentation identifies what the numbers identified as "Source" mean, and what all the labels for the Harvard data mean.

Key to SOURCE for Codes Identified by Public Comments:

- 1=Harvard
- 2=HCFA
- 3=Charge-based
- 4=Refinement panel, retained published value
- 5=Refinement panel, increased value
- 6=Refinement panel, decreased value
- 7=Other source
- 8=RUC recommendation, accepted by HCFA
- 9=RUC recommendation, increased by HCFA
- 10=RUC recommendation, decreased by HCFA
- 11=RUC recommendation, no change from published value
- 12=Specialty society recommendation, accepted by HCFA
- 13=Specialty society recommendation, increased by HCFA

- 14 = Specialty society recommendation, decreased by HCFA
- 15 = Specialty society recommendation, no change from published value
- 16 = Global period increased
- 17 = Global period decreased

Key to Harvard Data:

The data in the first two boxes of Harvard data summarize the differences in service work between the Harvard study and each of the Medicare Fee Schedules -- 1992 through 1995. In this way, the file provides a record of the evolution of the work RVUs since their initial complete publication. To make this comparison, all the codes are listed in 1995 RVUs. In other words, the effect of the 5.18% reduction for each service due to rescaling for budget neutrality has been eliminated. This allows you to identify services for which the RVUs have changed for reasons other than budget neutrality.

The labels are defined as follows:

modif	CPT two-digit modifier, if any
packhv	Harvard study global surgical package
pack95	MFS 95 global surgical package
desc95	1995 CPT descriptor
Hrvtotwk	Harvard study total work
MFSWK95	MFS 95 total work
ratio5h	ratio MFSWK95 to hrvtotwk
MFSWK92	MFS 95 total work
MFSWK93	MFS 94 total work
MFSWK94	MFS 93 total work
ratio2h	ratio MFSWK92 to hrvtotwk
ratio32	ratio MFSWK93 to MFSWK92
ratio43	ratio MFSWK94 to MFSWK93
ratio54	ratio MFSWK95 to MFSWK94
comm	identity of commenter
recwk	commenter's recommended total work value
amacod	AMA code for comment

Further Information --

- Global Period describes the global service packaging used in the Harvard study and in the MFS.
- Work RVUs are the total work RVUs for the MFS and for the Harvard RBRVS Study. The Harvard study amounts are those reported in the Harvard Phase III Final Report, unless indicated otherwise.
- Ratios describe the ratio of one Work RVU to another. A ratio greater than 1.0 indicates an increase in RVUs, a ratio less than 1.0 indicates a decrease.

The Harvard data in the other three boxes summarizes service work and time estimates for each code under review. The labels are defined as follows:

pack95	MFS 95 global surgical package
desc95	1995 CPT descriptor
hrvtotwk	Harvard study total work
notetw	denotes the service work was measured for the total service
pret	pre-service time, before O.R. entry
svdpre	indicates whether estimate is from a survey or prediction model (*=prediction)
itime	intra-service time
notett	denotes the service time was measured for the total service
imppt	immediate pre-and post operative time
svdimp	indicates whether estimate is from a survey or prediction model (*=prediction)
sdvis	number of later same day post visits
svdsdvis	indicates whether estimate is from a survey or prediction model (*=prediction)
sdvisdur	average duration of same day post visits
hvis	number of follow-up hospital visits after the day of surgery.
svdhvis	indicates whether estimate is from a survey or prediction model (*=prediction)
hvisdur	average duration of post-hospital visits
icuis	number of follow-up hospital visits after the day of surgery that are in the ICU.
offvis	number of follow-up office visits after the day of surgery w/in global period.
svdoffd	indicates whether estimate is from a survey or prediction model (*=prediction)
offvdur	average duration of post-office visits
low_n	if equal to "j", indicates low number of survey responses for the Harvard estimate (N < 5)
recwk	total work value recommended by commenter
MFSWK95	1995 MFS total work value
sp	Harvard study specialty surveyed
phase	Harvard study phase service was studied in
twput	Harvard estimate of total work per minute (if relevant)
iwput	Harvard estimate of intra work per minute (if relevant)

Further Information:

- Specialty and phase (Source of Data) - The specialty surveyed in the Harvard Study is listed first (2-digit code), followed by an indicator of when the service was studied. An "n" indicates the time and work estimates are from the Harvard Study, with the intra-

service estimates derived from the phase I and II national surveys. A "3" indicates the time and work estimates are derived from the phase III surveys of technical expert panels. An 'xx' listed for specialty indicates two or more specialties were surveyed.

- Total Work - Estimate of total-service work. For the Harvard study estimates, the work values are derived primarily from the Harvard, Phase III results. The exceptions are for services where the global surgical period has been revised since the Harvard Study. For these services, the Harvard total work value has been adjusted to fit the new period. Harvard work values were multiplied by a constant factor to place them on the 1995 MFS scale of work.
- IWPUT - Harvard intra-work per unit time, equals intra work divided by intra time. If work and time were measured for the "total" service, work per unit time is equal to total work divided by total time (which is listed in the intra time column for these services). In these cases, total work per unit time is listed in parentheses under the total work estimate. This IWPUT is unadjusted for changes in work since the Harvard study.
- Pre- Before O.R. entry -- The amount of time (in minutes) spent by the surgeon on the day before and day of a procedure, up to admission to the operating room.
- Intra-Time -- The time spent by the physician performing the service itself (i.e. skin to skin time for incisional services or patient encounter time for office visits). For selected services, total rather than intra time is listed. These services are indicated with a "t" to the right of the time estimate.
- Immediate Pre-Post -- Immediate pre-and post operative time -- For surgical services, the amount of time spent by the surgeon from the admission to the operating room to the skin incision or beginning of the procedure, plus the time from skin closure until the patient leaves the operating room. For evaluation and management services, includes total pre- and post-service time.
- Later Same Day Post -- The amount of time spent by the surgeon after the patient leaves the recovery room on the day of the procedure. These data include the **number** and **duration** of surgeon post-operative visits to the patient during this period. The **Type** of visit is measured by minutes in increments of five.
- Hospital Post-Op -- The amount of time spent by the surgeon for in-hospital post-operative care after the day of the procedure. These data include the **number**, **duration**, and **ICU Visits** of surgeon post-operative visits to the patient during this period. The **Type** of visit is measured by minutes in increments of five.
- Office Post-Op -- The amount of time spent by the surgeon for post-operative care in the office after the day of the procedure. These data will include the **number**, and **duration** of post-operative visits to the patient during this period. The **Type** of visit is measured by minutes in increments of five.
- MFS95 Work -- The Medicare Fee Schedule Work Value for 1995.

AMA Procedure Profiles Analysis

The data reports present several selected types of information for each code under review in the five year review of the RBRVS. This information is intended to provide a "profile" of each code to assist AMA/Specialty Society RVS Update Committee in the evaluation of physician work.

The first box presents information on the characteristics of the beneficiaries that receive each service. The beneficiary characteristics data are from a 5% sample of Medicare physician/supplier claims for the first six months of 1994. These data provide information on a variety of factors which may be associated with health status or utilization. Included are information on the proportion of claims for beneficiaries that are: age 75 and over; age 85 and over; nonwhite; female; disabled only (non-aged, non-ESRD); ESRD only (non-aged, non-disabled), and; aged or disabled with ESRD. Location information is also provided -- in particular, the proportion of claims for the service that are provided in rural localities. (Rural localities are defined as Medicare payment localities that have more than 50% of the population outside of Metropolitan Statistical Areas (MSAs) according to the 1990 census.)

The second and third boxes provide frequency and site of service data from Medicare physician claims for 1992 and for the first half of 1994. These data are from HCFA's procedure summary files which contain information on virtually 100% of claims incurred in a given period. The 1994 frequency data are from the first six months of the year, and have been annualized for comparison with 1992 frequency. The average annual change in frequency and the average change in the hospital inpatient share of frequency are also presented.

The fourth box presents specialty mix information from the HCFA procedure summary file for the first six months of 1994. The specialties were ranked in descending order according to the share of total frequency for each code. The top eight specialties with at least 2% of total frequency for the code are displayed.

The last box presents information on the diagnosis of patients receiving each service. These data are also drawn from the 5% sample of Medicare physician/supplier claims for the first six months of 1994. Medicare physician/supplier claims contain up to four "claim-level" ICD9 diagnosis codes. These (typically five-digit) diagnosis codes have been truncated to three-digit codes. Table 1 reports the three-digit claim-level ICD9 codes most commonly reported for each service. The percentage reported is the number of times a diagnosis code was reported out of the total number of claim-level diagnosis codes possible for a service. (For example, if there are 10 claims for a given service then there are 40 possible claim-level diagnosis codes that could be reported.) Descriptors for the three-digit ICD9 codes are also provided.

Because the summary statistics for the beneficiary characteristics and diagnosis data are based on a sample of claims (rather than virtually 100% of claims as for the frequency, site of service and specialty mix data), these measures will be missing for many low-volume codes. There will also be some sampling error in these estimates, particularly among low-volume codes.

Specialty Society Acronyms

AAAI	American Academy of Allergy & Immunology
AACAP	American Academy of Child & Adolescent Psychiatry
AAD	American Academy of Dermatology
AAEM	American Association of Electrodiagnostic Medicine
AAFP	American Academy of Family Physicians
AAFPRS	American Academy of Facial Plastic and Reconstructive Surgery
AAN	American Academy of Neurology
AANS	American Association of Neurological Surgeons
AAO	American Academy of Ophthalmology
AAO-HNS	American Academy of Otolaryngology - Head and Neck Surgery, Inc.
AAOA	American Academy of Otolaryngic Allergy
AAOMS	American Academy of Oral and Maxillofacial Surgeons
AAOS	American Academy of Orthopaedic Surgeons
AAP	American Academy of Pediatrics
AAPA	American Academy of Physician Assistants
AAPM	American Academy of Pain Medicine
AAPMR	American Academy of Physical Medicine and Rehabilitation
AAPS	American Association of Plastic Surgeons
AATS	American Association for Thoracic Surgery
ACC	American College of Cardiology
ACCP	American College of Chest Physicians
ACEP	American College of Emergency Physicians
ACG	American College of Gastroenterology
ACNP	American College of Nuclear Physicians
ACOG	American College of Obstetricians and Gynecologists
ACP	American College of Physicians
ACPM	American College of Preventive Medicine
ACR	American College of Radiology
ACRrh	American College of Rheumatology
ACS	American College of Surgeons
AGA	American Gastroenterological Association
AGS	American Geriatrics Society
ALROS	American Laryngological, Rhinological, and Otological Society
AMA	Aerospace Medical Association
AMDA	American Medical Directors Association
AMSUS	Association Military Surgeons of the US

ANA	American Nurses Association
AOA	American Osteopathic Association
AOA-HCP	American Optometric Association
AOFAS	American Orthopaedic Foot and Ankle Society
AOTA	American Occupational Therapy Association
APA	American Psychiatric Association
APA-HCP	American Psychological Association
APMA	American Podiatric Medical Association
APSA	American Pediatric Surgical Association
APTA	American Physical Therapy Association
ASA	American Society of Anesthesiologists
ASAM	American Society of Addiction Medicine
ASAS	American Society of Abdominal Surgeons
ASC	American Society of Cytopathology
ASCO	American Society of Clinical Oncology
ASCP	American Society of Clinical Pathologists
ASCRS	American Society of Colon and Rectal Surgeons
ASCRS2	American Society of Cataract and Refractive Surgery
ASDS	American Society for Dermatologic Surgery, Inc.
ASGE	American Society for Gastrointestinal Endoscopy
ASGS	American Society of General Surgeons
ASH	American Society of Hematology
ASHA	American Speech-Language Hearing Association
ASIM	American Society of Internal Medicine
ASMS	American Society of Maxillofacial Surgeons
ASPRS	American Society of Plastic and Reconstructive Surgeons, Inc.
ASRM	American Society of Reconstructive Microsurgery
ASRM2	American Society of Reproductive Medicine
ASTRO	American Society for Therapeutic Radiology and Oncology
ATS	American Thoracic Society
AUA	American Urological Association
AUR	Association of University Radiologists
CAP	College of American Pathologists
CLAO	Contact Lens Association of Ophthalmologists
ICS-US	International College of Surgeons - US Section
JCAI	Joint Council of Allergy & Immunology
NASW	National Association of Social Workers
RPA	Renal Physicians Association
RSNA	Radiological Society of North America
SCCM	Society of Critical Care Medicine

SCVIR	Society of Cardiovascular & Interventional Radiology
SID	Society for Investigative Dermatology
SNM	Society of Nuclear Medicine
STS	Society of Thoracic Surgeons
SVS	The Society for Vascular Surgery

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE RBRVS FIVE-YEAR REVIEW

RUC RECOMMENDATIONS

Evaluation and Management Services

Comments

Comments were submitted by a number of specialty societies representing primary care physicians recommending that the CPT codes for evaluation and management services (E/M) be included in the five-year review of the RBRVS. Comments from the American Society of Internal Medicine (ASIM) and the American College of Physicians (ACP) were referred to the RUC, focusing particularly on the need to review the relative values for office visits, hospital visits, and consultations. The American Academy of Family Physicians (AAFP) had submitted similar comments, but this comment letter was not referred to the RUC. To prepare for the five-year review, the AAFP and ASIM had conducted large surveys of their membership in late 1994 to determine which codes should be included and why. Their comments offered three major reasons for including E/M services in the review:

- **The physician work involved in the services has increased since the time that the Harvard RBRVS study was conducted. Sweeping changes in the delivery of health care have had a major impact on primary care services. The growth of managed care and pressure to contain costs have created a great deal of pressure to keep patients out of hospitals and emergency rooms and, if they are hospitalized, to discharge them as quickly as possible. As a result, the typical patient seen in both the office and the hospital is more complex than in the mid-1980s. In addition, a larger proportion of the frail elderly population is living in the community and, therefore, being seen by physicians in the office rather than being cared for in an institutional setting. Hospitalized patients are likely to be hospitalized for a very short period, so subsequent hospital visits are more likely to occur on the second or third hospital day than the sixth or seventh. During office visits and subsequent hospital visits, physicians must make diagnostic and treatment decisions within a shorter time frame and based more on history, examination, and test results, rather than observation over several days or a week. Changes in the delivery system have had an even greater impact on postservice work. Relative to the mid-1980s, much more time and effort is required to:**
 - document care and respond to questions regarding medical necessity and adherence to quality standards;
 - obtain or provide authorizations for tests and referrals;
 - coordinate care with other health professionals and family members, particularly for elderly patients; and
 - provide education regarding issues such as fall prevention and adverse drug reactions, and respond to questions from an increasingly well-informed patient population.

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The amount of work involved in documenting services in the medical record, for example, has increased dramatically. The emphasis of Medicare and other insurers on medical necessity has been greatly heightened, and physicians are required to document both (1) that they did what they claim they did and (2) that what they did was medically necessary. Demands by Medicare for better documentation of the services actually provided to patients in visits and consultations were, in fact, among the major reasons for developing the new E/M coding system.

- **These services are undervalued relative to most of the other services on the RBRVS.** It would be difficult to find a non-E/M service on the RBRVS which involves 25 minutes of intraservice time and is valued below the 0.94 RVUs of a 99214 (office visit, established patient). For virtually every service on the RBRVS, the ratio of total work RVUs to total minutes of service is 0.05. For 99214, with 35 minutes total time assumed in the Harvard study, the ratio is only 0.027. By definition, the highest level E/M services involve a "comprehensive examination" and "medical decision making of high complexity," yet the RVUs are lower than procedures that require less time, less mental effort and judgement, and less technical skill and physical effort. Code 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*], for example, involves 22 minutes of intrawork and 44 minutes of total time and has 1.81 RVUs, compared with 99215 [*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.*], which involves 40 minutes of intrawork, 55 minutes of total work, and has 1.51 RVUs. Code 45378 [*Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)*] involves 39 minutes of intrawork and 93 minutes of total time and has 3.70 RVUs, compared with 99205, which involves 60 minutes of intrawork and 83 minutes of total work, but only has 2.28 RVUs. The ACP's comments stated that an intrawork per unit time (IWPUT) analysis by the College of most of the services on the RBRVS found that the E/M services are currently at the 3.5 percentile, meaning that 96% of the services on the RBRVS are rated as being more difficult than E/M. Those commenting believe that the current relationships between the E/M services they provide and the non-E/M services provided by these same physicians are not correct.
- **The current CPT-coded services were never directly surveyed or studied in the Harvard RBRVS study.** Harvard conducted its national surveys from 1986 through 1988, so they were completed four years prior to publication of the current E/M codes in CPT and their use in the Medicare RBRVS payment system. At the time that the Harvard study was conducted, E/M services were not defined based on the level of history, examination, and medical decision making. The vignettes used in this study were never intended to distinguish physician services based on these factors; they provided a brief description of the patient's chief complaint, presenting medical problem, or diagnosis, but did not provide information about the physician service being provided. The data from these surveys could not be directly used to establish RVUs for the new codes. Instead, a "crosswalk" was estimated from the old to the new coding system. Pre- and postwork was not directly surveyed, nor had the postservice period been defined at the time the codes and relative values were implemented, so the Harvard study made no attempt to measure the physician work that occurs from the day following the visit until the next face-to-face encounter occurs. Whatever telephone calls and other physician services are provided in this period are considered to be "bundled" into the RVUs for the visit, yet this bundle was never defined. In addition, as noted above, documentation requirements have greatly increased so, for example, physicians must document

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that each element of the service definition has actually been provided. For example, to document a "comprehensive" examination, the physician must record what organs have been examined to support that a single-system or multisystem exam has been done.

Comments submitted by the American Medical Directors Association (AMDA) and the American Association of Homecare Physicians (AAHP) were also referred to the RUC for review. These comments suggested that the relative values assigned to nursing home and home visits should also be included in the five-year review.

The CMDs submitted comments on the ophthalmology codes for eye examinations, comparing them to the relative values for office visits. The RUC considered these codes along with the office visit codes.

RUC Review

The RUC agreed with all the commenters that an in-depth review of the work involved in office and hospital visits and consultations was warranted. The RUC has previously revisited the established relative values for many families of services within CPT and for virtually all specialties; however, the five-year review is the first opportunity to review the relative values assigned to the E/M codes introduced in 1992.

The RUC had developed a modified survey instrument for use in the five-year review. To address the E/M codes, the questionnaire was further modified (1) to make it more relevant to E/M services and (2) to address some of the specific points made in the comments:

- For procedural services, surveyed physicians were asked about four components of postoperative care: postwork on the day of the procedure, ICU visits, other inpatient visits, and office visits after discharge. To obtain data on the postservice work for E/M services, surveyed physicians were asked about five components of work following the face-to-face encounter: documentation of the service provided; arranging for further services; reviewing results of studies; communicating further with the patient, family, and other professionals; and, providing written or telephone reports to Medicare or other third party payors.
- To assess the relationship between E/M services and procedural services, the services on the reference list for each survey were divided into Category A and Category B. Category A was comprised of reference services that were other E/M services that were not being surveyed as part of the joint study; Category B was comprised of procedural reference services. In choosing the two reference services to use as comparisons for each service being rated, respondents were asked to choose one from Category A and one from Category B.
- The questionnaire for other services in the five-year review asked whether the work involved in the service had changed in the last five years and, if so, how. In the E/M questionnaire, these questions were modified. Physicians responding "Yes" to the question of whether the work had changed were then asked whether the typical complexity of patient problems in the relevant setting, the typical complexity of patients in the inpatient setting, and the work associated with coordination and documentation has increased, decreased, or stayed the same in that period.

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Standard RUC procedures allow all the specialty societies expressing interest in developing data on a code that is under review to participate in the survey process. In addition to the AAFP, ASIM, and ACP, as many as 8 other groups participated in developing data for each code, including pediatricians, osteopathic physicians, geriatricians, nurses, physician assistants, and physicians specializing in rheumatology, cardiology, and neurology. To ensure that the survey results would be as valid as possible, specialty representatives agreed on the following survey procedures before the survey was conducted:

- The clinical vignettes used in the surveys were those that had been validated by the CPT Editorial Panel and included in either the main CPT book or the clinical examples supplement (Appendix D). The RUC survey, therefore, used clinical vignettes that had been empirically demonstrated to be appropriate for the CPT codes being reviewed.
- A standard set of reference services was chosen for use in the surveys. To avoid the problem of comparing the services being surveyed to other E/M services that would themselves be moving targets, the Category A services selected were those that the surveying specialties considered to be appropriately valued in the current RBRVS: preventive medicine (99381-99397), observation care (99217-99219), emergency room visits (99281-99283), and critical care (99291-99292).
- The issue of whether the IWPUT is the same or different for all levels of service within an E/M family was addressed by HCFA in 1992. HCFA concluded at that time that IWPUT is constant within a family from the lowest to highest level of service. The group agreed not to revisit this question, but to instead survey one or two codes within each family and then extrapolate to the other codes based on the IWPUT of the surveyed codes, maintaining a constant IWPUT for each level of service. This decision also meant that each survey respondent could be asked to rate the work of fewer codes, which seemed likely to increase the response rate for the survey.

The joint efforts of these societies resulted in about 150 completed surveys for each surveyed code. A median value was calculated for each specialty, and these values were weighted to develop the recommended RVUs. This weighting process took into account the percentage of the services that are provided by each specialty, the number of respondents from the specialty, and other factors affecting the validity of each specialty's survey process.

RUC Recommendations and Rationale

Office and Hospital Visits

The RUC found the arguments made by the specialties and the results of the survey very compelling and recommends increases in the RVUs for office visits for new and established patients, subsequent hospital visits, and inpatient and outpatient consultations. In particular, the RUC found that the surveyed RVUs produced a more reasonable relationship between E/M and non-E/M services on the RBRVS, with the ratio of total work to total time moving closer to the level that has been consistently identified for all other services. For instance, in the example above comparing 99215 and

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12002, the RVUs for 99215 would be increased from 1.51 to 1.90, which is slightly more than 12002 and reflects the greater time and mental effort and judgement involved in the E/M service, as well as the increased complexity of postwork since the service was originally valued.

In addition to the survey results, the RUC's recommendations are also based on rigorous multidisciplinary review by surgeons and other specialists who share the primary care groups' views regarding the increase in the work of E/M services in the last five years and the failure of the current RVUs to appropriately recognize the time and effort involved in both intra- and postservice work. Although primary care physicians are a minority of the RUC members, the RUC's votes on adoption of the recommendations for these services were nearly unanimous.

Objective data on trends in the delivery of care confirms the statements made by the primary care societies and RUC members. Attachment 1 shows a clear shift in care from inpatient to outpatient settings. Attachment 2 graphically depicts the RUC recommended RVUs for many of the E/M code families so that their values may be seen in relation to one another.

The RUC's evaluation of these recommendations focused principally on the work involved in them, how that work has changed over time, and how the service work is related to the work of other E/M and non-E/M services. The survey respondents' ratings of work appeared to be accurate. Some problems were noted in the survey results for postservice time, however. Within the questionnaire, the splitting of reported postservice time into documentation, arranging for further studies, reviewing study results, communicating with the patient, family, and other professionals, and providing reports to insurers, seems to have led to overestimates of total postservice time. This may be due either to rounding, to overlap within categories, or just to the tendency of survey respondents to want to fill in all the boxes on a questionnaire. The RUC concluded, therefore, that although postservice time is underestimated in the Harvard data considering what is involved in these services in 1995, it is likely overestimated in the RUC survey data. The correct estimate of postservice time is likely somewhere between these two estimates. The time estimates for hospital services were more problematic than the estimates for office services, because the intraservice period is defined as time on the patient's floor. Many services, such as arranging for further studies and reviewing results, could take place either on the patient's floor, elsewhere in the hospital, or in the physician's office, thus making precise estimates difficult to obtain.

The uncertainty surrounding the postservice time estimates did not affect the extrapolation from surveyed to nonsurveyed services within a family, however. Extrapolation was based on work per unit time, and this remains constant within each family whether the surveyed postservice times are used as is or are reduced by some percentage. The typical times listed in the CPT descriptors were used for this purpose.

Consultations and Home Visits

Another problem in the survey results was that, although generalists were well-represented in the survey, subspecialists were not as well represented. As indicated above, survey medians were weighted to ensure that responses from those who provide the services most frequently were weighted most heavily in the recommendations. Most office and hospital visits are provided by primary care physicians, but office and hospital consultations are provided more by internal medicine subspecialists. Two of the three home visits that were surveyed are provided mostly by podiatrists, and other home visit services are provided by special groups of physicians, such as the members of the AAHP, in addition to the major groups surveyed. This

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made the weighting process more problematic, so the consultation codes were referred to a multidisciplinary facilitation committee of the RUC. The decisions made by the facilitation committee and adopted by the RUC are discussed in the table below. (Note that the "Key" for these services is somewhat different as a "4" indicates the recommendations were developed by this facilitation committee, instead of indicating that the RVUs are lower than those recommended by the specialty societies.)

Podiatrists were not included in the survey of home visit services and there were relatively few responses from the AGS and the AAHP compared to the large primary care societies. In retrospect, it also seemed that all the home visit codes may need to be surveyed, rather than the sample selected. The RUC is recommending on an interim basis, therefore, that the current RVUs be maintained, but will review new and more comprehensive survey data at its next meeting.

Emergency Room Visits and Critical Care

Comments submitted by the American College of Emergency Room Physicians (ACEP), the National Association of Medical Directors of Respiratory Care (NAMDRC), the American College of Cardiology (ACC), and the Society of Critical Care Medicine (SCCM) for the RVUs of emergency room and critical care codes were also referred to the RUC by HCFA. In general, the comments stated the physician work is intense, often involving integrating care for several patients each with urgent problems.

ACEP conducted a survey of the two highest level emergency room visit codes. This was separate from the survey of other E/M codes discussed above, and 44 responses were obtained. The RUC did not believe that the arguments and survey data presented by ACEP were sufficiently compelling to justify the recommended increases in these services.

The SCCM recommendations are based on survey responses from nearly 100 intensivists, emergency room physicians, and pulmonologists. Although code 99291 may be reported for 31-74 minutes of critical care, the median surveyed time was 60 minutes, and the service was considered to require more work than the key reference services, including cardiopulmonary resuscitation (code 92950, 3.80 RVUs). The RUC recommends that the RVUs be increased from 3.64 to 4.00 for code 99291 and from 1.84 to 2.00 for code 99292.

Ophthalmology Visits

The CMDs compared 92002 [*Eye exam new patient*], 92004 [*Eye exam new patient*], 92012 [*Eye exam established patient*], and 92014 [*Eye exam and treatment*] to E/M office visit codes. The RUC agrees with the comparisons made by the CMDs, and recommends that a permanent link be established between ophthalmology eye exam codes and the E/M codes. Code 92002 should be equal to 99202 [*Office/outpatient visit, new*], 92004 should equal the average of 99203 [*Office/outpatient visit, new*] and 99204 [*Office/outpatient visit, new*], 92012 should be equal to 99213 [*Office/outpatient visit, established*], and 92014 should be equal to 99214 [*Office/outpatient visit, established*]. The RUC-recommended RVUs for the eye exam codes reflect the recommended increases in the RVUs for codes 99202, 99203, 99204, 99213 and 99214; however, for all the codes except 92014, the RUC recommended RVUs represent a reduction from the 1995 RVUs for eye exam codes.

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Code	Descriptor	95 RVU	RUC Rec RVU	Intra-Time	IWPUT	RUC Rationale	Key
OFFICE VISITS							
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.	0.38	0.39	10	0.022	Codes 99203, 99205, 99213, and 99215 were surveyed by the specialty societies using the survey instrument described above. The survey indicated that the new patient office visit codes are currently undervalued by 5-6%, but that the established patient office visits are undervalued by about a third. Changes in the delivery of health care, such as the need to manage more complex patient problems in the office and the need to manage the chronic diseases and multiple comorbidities of elderly patients, have had a particularly significant impact on the physician work involved in providing office services to established patients. In addition, postservice work, such as arranging for further studies and communicating further with the patient, family, and other professionals, is a greater proportion of total work than it used to be and than is suggested by the Harvard study.	1
99202	Office/outpatient visit, new ... expanded problem focused history; expanded problem focused examination; straightforward medical decision making.	0.75	0.79	20	0.022		
99203	Office/outpatient visit, new ... detailed history; detailed examination; medical decision making of low complexity.	1.14	1.20	30	0.023		
99204	Office/outpatient visit, new ... comprehensive history; comprehensive examination; medical decision making of moderate complexity.	1.71	1.80	45	0.022		
99205	Office/outpatient visit, new ... comprehensive history; comprehensive examination; medical decision making of high complexity.	2.28	2.41	60	0.022		

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Code	Descriptor	95 RVU	RUC Rec RVU	Intra- Time	IWPUT	RUC Rationale	Key
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	0.17	0.25	5	0.023	See previous page.	1
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.	0.38	0.50	10	0.023		
99213	Office/outpatient visit, established ... detailed history; detailed examination; medical decision making of low complexity.	0.55	0.80	15	0.022		
99214	Office/outpatient visit, established ... comprehensive history; comprehensive examination; medical decision making of moderate complexity.	0.94	1.27	25	0.023		
99215	Office/outpatient visit, established ... comprehensive history; comprehensive examination; medical decision making of high complexity.	1.51	1.90	40	0.023		

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KEY: 1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU developed by facilitation committee; 5 = Adopt decreased RVU to maintain neutrality

Code	Descriptor	95 RVU	RUC Rec RVU	Intra- Time	IWPUT	RUC Rationale	Key
HOSPITAL VISITS AND FOLLOW-UP CONSULTATIONS							
99221	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.	1.06	1.06	30	0.024	The specialty surveys did not find that the work of initial hospital care, which is essentially the hospital admission service, had increased sufficiently to justify an increase in the RVUs. There has been a clear trend in claims for these services of the highest level service being reported more frequently and the first and second level of service being reported less frequently, suggesting that coding is accounting for some increased patient complexity. In addition, increases in preservice work may be showing up in the office visits as physicians try to avoid hospital admissions, and increases in postservice work may be reflected in subsequent hospital visits and discharge day services.	2
99222	Initial hospital care ... comprehensive history; comprehensive examination; medical decision making of moderate complexity.	1.84	1.84	50	0.024		
99223	Initial hospital care ... comprehensive history; comprehensive examination; medical decision making of high complexity.	2.57	2.57	70	0.024		

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Code	Descriptor	95 RVU	RUC Rec RVU	Intra-Time	IWPUT	RUC Rationale	Key
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.	0.51	0.65	15	0.018	The RUC reviewed the subsequent hospital visit and follow-up inpatient consultation codes and the survey data on them, and determined that the relative values for these two families of services should be equivalent. The time and complexity of the lowest, middle and highest levels of subsequent hospital care and follow-up inpatient consultations were found to be very similar, as are the CPT descriptions for each level. The RUC recommends increasing the RVUs to the levels supported by survey data.	4
99232	Subsequent hospital care ... expanded problem focused interval history; expanded problem focused examination; medical decision making of moderate complexity.	0.88	1.30	25	0.021		
99233	Subsequent hospital care ... detailed interval history; detailed interval examination; medical decision making of high complexity.	1.25	1.75	35	0.021		
99261	Follow-up inpatient consultation for an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit.	0.36	0.65	10	0.022		
99262	Follow-up inpatient consultation, established ... expanded problem focused interval history; expanded problem focused examination; medical decision making of moderate complexity.	0.74	1.30	20	0.022		
99263	Follow-up inpatient consultation, established ... detailed interval history; detailed examination; medical decision making of high complexity.	1.16	1.75	30	0.019		

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Code	Descriptor	95 RVU	RUC Rec RVU	Intra-Time	IWPUT	RUC Rationale	Key
INPATIENT AND OUTPATIENT CONSULTATIONS							
99251	Initial inpatient consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.	0.54	0.63	20	0.023	The RUC reviewed the office consultation and initial inpatient consultation codes and survey data on them and concluded that the RVUs for the two families of services should be equivalent at all levels except the highest. This preserves the same relationship that exists in the current RVUs for these services, but recognizes that the work of the services has increased over time and that they are undervalued compared to key reference services. The RUC concluded that there is little difference, in either CPT definition of the service or physician work involved, between an office/outpatient consultation and an inpatient consultation. The RVUs were increased to the values supported by survey data. These data were weighted more heavily toward the responses from internal medicine subspecialists since they are the most frequent providers of the services.	4
99252	Initial inpatient consultation, new or established ... expanded problem focused history; expanded problem focused examination; straightforward medical decision making.	1.13	1.25	40	0.022		
99253	Initial inpatient consultation, new or established ... detailed history; detailed examination; medical decision making of low complexity.	1.56	1.90	55	0.023		
99254	Initial inpatient consultation, new or established ... comprehensive history; comprehensive examination; medical decision making of moderate complexity.	2.27	2.50	80	0.022		
99255	Initial inpatient consultation, new or established ... comprehensive history; comprehensive examination; medical decision making of high complexity.	3.14	3.40	110	0.023		
99241	Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	0.54	0.63	15	0.026		
99242	Office consultation, new or established ... expanded problem focused history; expanded problem focused examination; straightforward medical decision making.	1.11	1.25	30	0.026		

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Code	Descriptor	95 RVU	RUC Rec RVU	Intra-Time	IWPUT	RUC Rationale	Key
99243	Office consultation, new or established ... detailed history; detailed examination; medical decision making of low complexity.	1.47	1.90	40	0.027	See previous page.	4
99244	Office consultation, new or established ... comprehensive history; comprehensive examination; medical decision making of moderate complexity.	2.23	2.50	60	0.026		
99245	Office consultation, new or established ... comprehensive history; comprehensive examination; medical decision making of high complexity.	2.96	3.21	80	0.028		

Code	Descriptor	95 RVU	RUC Rec RVU	RUC Rationale	Key
HOME VISITS					
99341	Home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity.	1.12	1.12	Two of the three home visit codes that were surveyed are provided mostly by podiatrists. Podiatrists were not included in the survey of home visit services and there were relatively few responses from the AGS and the AAHP compared to the large primary care societies. In retrospect, it also seemed that all the home visit codes may need to be surveyed, rather than the sample selected. The RUC is recommending on an interim basis, therefore, that the current RVUs be maintained, but will review new and more comprehensive survey data at its next meeting.	2
99342	Home visit, new ... expanded problem focused history; expanded problem focused examination; medical decision making of moderate complexity.	1.58	1.58		
99343	Home visit, new ... detailed history; detailed examination; medical decision making of high complexity	2.09	2.09		
99351	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving.	0.83	0.83		

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Code	Descriptor	95 RVU	RUC Rec RVU	RUC Rationale	Key
99352	Home visit, established ... expanded problem focused interval history; expanded problem focused examination; medical decision making of moderate complexity.	1.12	1.12	See previous page.	2
99353	Home visit, established ... detailed interval history; detailed examination; medical decision making of high complexity.	1.48	1.48		
EMERGENCY ROOM VISITS					
99284	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	1.68	1.68	ACEP argued that emergency medicine is unique in the E/M codes since emergency care is unscheduled. Because of this, time is not a reliable predictor of the work that is performed by emergency room physicians. The College also stated that problems in patient access to office-based primary care physicians have led to emergency department patients being sicker and more complex, and they noted that the physician documentation requirements have increased significantly for quality assessments and the encouragement of outpatient management modalities. The specialty recommended an RVU of 2.25 for 99284 and 3.23 for 99285 both of which represent the survey medians. The RUC questioned why, if these contentions were true, they would only affect the highest level codes. The RUC concluded that sufficient evidence had not been presented to support the argument that the work has increased, and recommends that the current RVUs be maintained.	2
99285	Emergency department visit... which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and mental status: comprehensive history; comprehensive examination; medical decision making of high complexity.	2.63	2.63		

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Code	Descriptor	95 RVU	RUC Rec RVU	RUC-Rationale	Key
CRITICAL CARE					
99291	Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; first hour	3.64	4.00	92% of the survey respondents stated that the patients are more complex. SCCM selected as one of the key reference services CPT code 92950 - cardiopulmonary resuscitation (3.80), noting that in performing CPR, the physician analyzes the patients heart rhythm, blood pressure, pulse, and blood gases. In judging the magnitude of the cardiorespiratory failure and implementing the treatment, the physician focuses on cardiorespiratory function. The procedure takes 20-30 minutes, but no longer than 30 minutes. In contrast, when providing critical care the physician analyzes the indicators used in providing CPR, plus additional factors, including brain protection and metabolic function, and often treats multiple organ failure. SCCM contends that the provision of critical care takes at minimum 31 minutes, and often lasts as long as 74 minutes. SCCM recommends that the RVUs of 99291 and 99292 be increased to 4.00 and 2.00 RVUs respectively. These higher values also represent the survey medians.	1
99292	Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; each additional 30 minutes	1.84	2.00		

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Code	Descriptor	95 RVU	RUC Rec RVU	RUC Rationale	Key
OPHTHALMOLOGY VISITS				CMD Comments	
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	1.01	0.79	A national coding organization (Med Index) lists the following services necessary for 92002: History, general medical observation, external ocular and adnexal examination, other diagnostic procedures as indicated, and mydriasis (optional). There are almost no "other diagnostic procedures" for which the ophthalmologist/optometrist does not bill separately. Hence, all of the other issues are equivalent to what a physician does for 99202.	3
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits	1.61	1.50	This same coding organization lists the following services for a "comprehensive level of service": History, general medical observation, external and ophthalmoscopic examination, gross visual fields, basic sensory motor examination. Often includes microscopy, dilation, tonometry. It appears that this is no different than what a provider does for the average of 99204 and 99203.	3
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	0.82	0.80	The services included in 92012 are listed under 92002. This level of service is no different than what a physician provides for 99213.	3
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits	1.06	1.27	The services required for 92014 are listed under 92004. These services are no more than a physician provides for 99214 visit.	1

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Attachment 1

The data on these graphs represent a time series comparison of inpatient days and outpatient visits. The American Hospital Association defines inpatient days as the "number of adult and pediatric days of care, excluding newborn days of care, rendered during the entire reporting period (one year)".¹ Outpatient visits are defined as those provided to individuals who are not lodged in the hospital while receiving hospital services. Further breakdown of the data is into General Short-term nongovernment not-for-profit and General Short-term nongovernment investor-owned (for profit). The definition of a general hospital is very broad in that it includes other specialty hospitals, such as obstetrics and gynecology; eye, ear, nose and throat; rehabilitation; and orthopaedic, whose facilities are open to the public. Short term is defined by the AHA as a hospital in which the average length of stay is less than 30 days.² The other characteristics of the two hospital types are self explanatory.

The data show a gradual decline in inpatient days and a dramatic increase in outpatient visits. From 1988 to 1993, the most recent year for which data are available, in the not-for-profit sector inpatient days saw a 5% decline while outpatient visits saw a 38% increase. Over this same period in the for profit sector inpatient days dropped by 4% and outpatient visits increased 34%. This data shows a distinct trend toward moving patients away from an inpatient setting to providing services on an outpatient basis. This changing patient distribution has had profound effects on the delivery of E/M services.

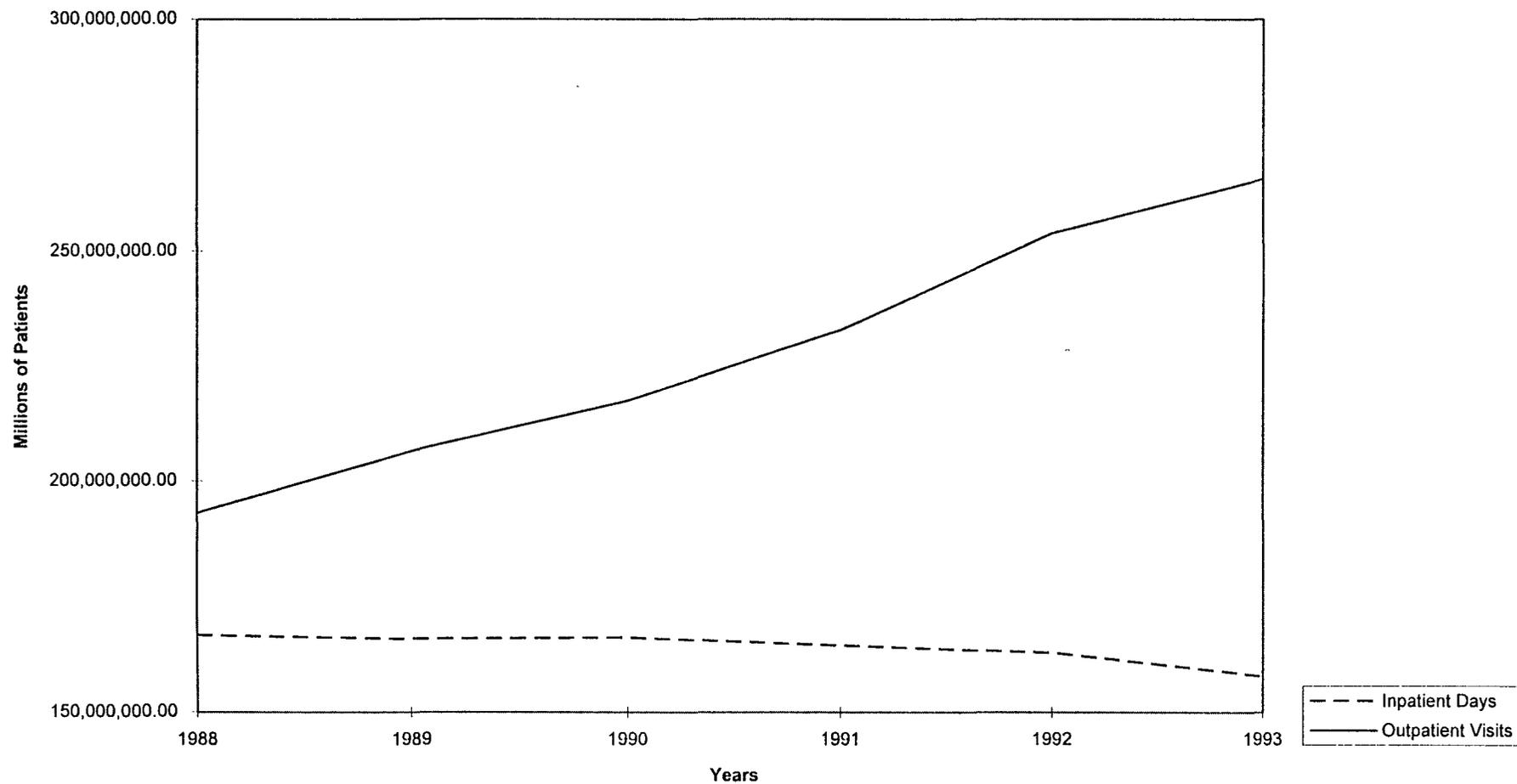
¹ The American Hospital Association, 1994/95 AHA Hospital Statistics, p.XXV, (1994).

² Ibid.

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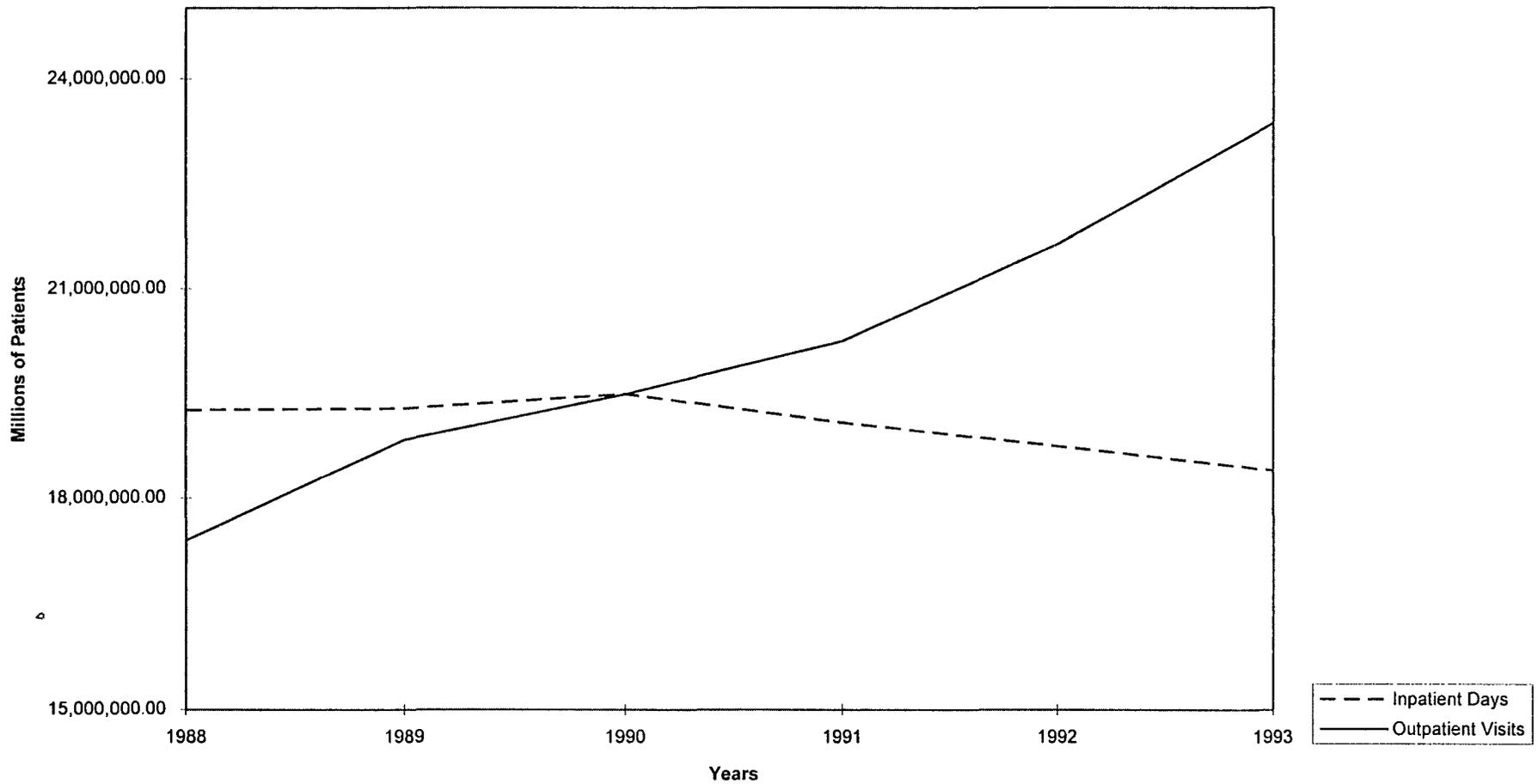
KEY: 1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU developed by facilitation committee; 5 = Adopt decreased RVU to maintain neutrality

General Short-term Hospitals, Nongovernment Not-for-profit Changing Patient Distribution



Data is from the American Hospital Association, *Hospital Statistics*, 1989-1994

General Short-term Hospitals, Nongovernment Investor-owned Changing Patient Distribution



Data is from the American Hospital Association, *Hospital Statistics*, 1989-1994

Attachment 2

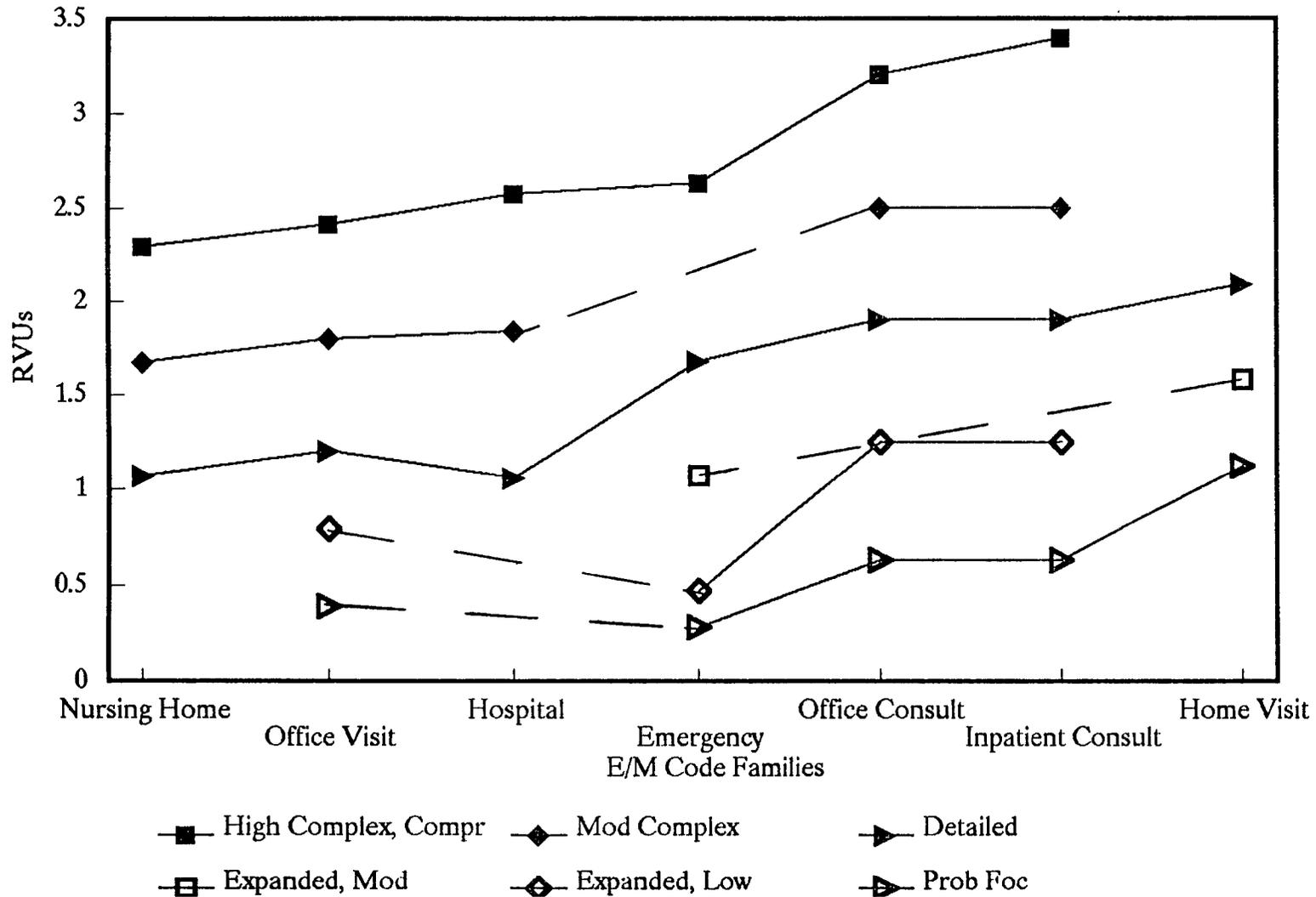
These two charts plot RUC proposed RVUs for families of E/M codes involving new patients and established patients. The charts' vertical axis represents the work RVUs proposed by the RUC. The horizontal axis describes the different families of E/M services: Nursing Home Visits, Office Visits, Hospital Services, Emergency Room Visits, Office Consultations, Inpatient Consultations and Home Visits. Across the chart, codes with similar CPT descriptors and level of complexity are connected to show the relationship of work RVUs across different settings. The trend or direction of the connecting lines help visualize the relationships among families of E/M services. To this end, the RUC reviewed the charts as a means of understanding the pattern and relationship of work RVUs among codes established by the RUC recommended values.

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Gradient of E/M Code Families – New Patients

RUC Recommended RVUs



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 99201 Global Period: XXX Current RVW: 0.38 Recommended RVW: 0.39

CPT Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

CPT Code: 99202 Global Period: XXX Current RVW: 0.75 Recommended RVW: 0.79

CPT Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

CPT Code: 99204 Global Period: XXX Current RVW: 1.71 Recommended RVW: 1.80

CPT Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

Source and Summary of Comment to HCFA on this service: AAP, ACP and others.

Increased complexity of patients due to shift from inpatient to outpatient setting over the last 5 - 7 years; increased post service work over the past 5 - 7 years due to the increased complexity of the patients and prevalence of managed care arrangements, E/M codes thought to be undervalued in general, and especially as compared to non E/M services, and low intra-service intensity of E/M codes as compared to all services studied by Hsiao.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The RVWs for these codes were extrapolated from the surveyed codes within this family of services, 99203 and 99205. In extrapolating, we assumed linear relationships within the family of services. The ratios of pre-service plus post-service time to intra-service time and the calculated intra-service intensities of 99203 and 99205 were used to perform the extrapolation. The intra-service intensities for 99203 and 99205 were calculated using the following formula:

$$\{RVW/[(pre-service + post-service time/CPT intra-service time) + 1] \} / CPT intra-service time.$$

Because of an inconsistency in the survey instrument for the hospital admit, follow-up, and consult codes, the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the office/outpatient visit and consult codes.

Based on the median of the ratios of pre-service plus post-service time to intra-service time and the calculated intra-service intensities of 99203 and 99205, the ratio of pre-service plus post-service time to intra-service time and intra-service intensity were extrapolated to 99201, 99202, and 99204. Once these numbers were available, the RVW was calculated using the above formula.

Public Comments

06-Jul-95

Code: 99201

1995 RVUs: 0.38

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 788,932 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAFP, AAN, AAP, ACP, ANA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPM, AAPMR, ACCP, ACEP, ACOG, ACRh, ACS, AGS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99201	42.2	9.9	8.2	59.5	9.6	0.2	0.6	17.5

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99201	1002657	849292	-8

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99201	0.1	0	-0.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99201	dermatology	13.6
	general surgery	8
	general/family practice	17.8
	internal medicine	6.1
	orthopedic surgery	9.2
	otolaryngology	6.4
	podiatry	16.1

Public Comments

06-Jul-95

urology	3.4
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Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99201	110	1.5	DERMATOPHYTOSIS
	702	1.9	OTHER DERMATOSES
	703	1.2	DISEASES OF NAIL

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99201							
ACP		XXX	XXX	0.38	0.38	1.00	0.38

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99201								
ACP	0.39	0.38	1.00	1.03	0.97	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
99201								
ACP	XXX	0.38				10		4

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
99201									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99201									
ACP				INCR	0.38	xx	n		0.028

Public Comments

25-Sep-95

Code: 99202

1995 RVUs: 0.75

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 2,780,697 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, ACP, ANA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPM, AAPMR, ACCP, ACEP, ACOG, ACRh, ACS, AGS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99202	42.4	9.7	8.2	61	9.1	0.2	0.4	14.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99202	2977826	2978334	0

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99202	0.1	0	-0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99202	dermatology	14.6
	general surgery	4.8
	general/family practice	17.9
	internal medicine	6.7
	orthopedic surgery	10.5
	otolaryngology	8.9
	podiatry	18.8

Public Comments

25-Sep-95

urology	3.6
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Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99202			
	110	1.6	DERMATOPHYTOSIS
	401	1.1	ESSENTIAL HYPERTENSION
	702	1.4	OTHER DERMATOSES
	703	1.3	DISEASES OF NAIL
	715	1.1	OSTEOARTHRISIS AND ALLIED DISORDERS
	726	1.2	PERIPHERAL ENTHESOPATHIES AND ALLIED SYNDROMES
	735	1	ACQUIRED DEFORMITIES OF TOE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99202							
ACP		XXX	XXX	0.72	0.75	1.04	0.73

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99202								
ACP	0.77	0.75	1.01	1.05	0.97	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
99202								
ACP	XXX	0.72				20		8

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99202									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99202									
ACP				INCR	0.75	xx	n		0.027

Public Comments

06-Jul-95

Code: 99204

1995 RVUs: 1.71

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 2,242,986 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, ACP, ANA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPM, ACCP, ACEP, ACOG, ACRh, ACS, AGS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA, RPA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99204	41.5	9.1	12.2	61.1	10.5	0.2	0.5	9.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99204	2417923	2356954	-1.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99204	0.1	0	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99204	cardiovascular disease	4.3
	general/family practice	12.4
	internal medicine	18.3
	obstetrics/gynecology	5.5
	ophthalmology	9.8
	orthopedic surgery	10.5
	otolaryngology	6.2

Public Comments

06-Jul-95

urology	4.8
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Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
99204		
250	1.2	DIABETES MELLITUS
366	2	CATARACT
401	2.5	ESSENTIAL HYPERTENSION
715	1.6	OSTEOARTHRISIS AND ALLIED DISORDERS
786	1.2	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99204							
ACP		XXX	XXX	1.59	1.71	1.08	1.59

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99204								
ACP	1.73	1.71	1.00	1.09	0.99	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
99204								
ACP	XXX	1.59				45		18

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
99204									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99204									
ACP				INCR	1.71	xx	n		0.026

FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

Code: 99203 Global Period: XXX Current RVW: 1.14 Recommended RVW: 1.20

EPT Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

Source and Summary of Comment to HCFA on this service: AAP, ACP and others.

Increased complexity of patients due to shift from inpatient to outpatient setting over the last 5 - 7 years; increased post-service work over the past 5 - 7 years due to the increased complexity of the patients and prevalence of managed care arrangements, E/M codes thought to be undervalued in general, and especially as compared to non E/M services, and low intra-service intensity of E/M codes as compared to all services studied by Hsiao.

CLINICAL DESCRIPTION OF SERVICE:

Vignettes Used in Survey:

AAP/ANA/AOA: Initial office visit for a 50 year-old female with dyspepsia and nausea. Detailed history including gastrointestinal system, food character of discomfort, and bowel habits. Detailed exam including chest and abdomen, and a rectal with hemoccult. Medical decision making of low complexity and discussion of diet, medication, diagnostic tests and follow-up with the patient.

AAP/AOA: Initial office visit for a new patient, a 6 year old male with a two day history of lower abdominal pain with occasional vomiting. Detailed history including gastrointestinal system, fever, appetite, and characteristics of pain and bowel movements. Detailed examination of chest and abdomen including rectal examination. Medical decision making of low complexity and ordering of laboratory studies and initiation of plans for surgical consultation.

ACC: Initial office visit for a 67 year old diabetic man complaining of exertional chest discomfort. The physician performs a detailed history and detailed physical examination including the vascular system in the neck and extremities, fundi, heart, lungs and abdomen. Medical decision making is of low complexity and involves ordering electrocardiogram, exercise stress test, lab work to check lipid profile, electrolytes and glucose, and initiating medical therapy. Alternative approaches to diagnosis and therapy are explained to the patient including the possibility of hospitalization for coronary arteriography.

ACP/AOA/ASIM: Initial office visit for evaluation, diagnosis and management of painless gross hematuria in new patient, without cystoscopy. Detailed history including genitourinary system and bleeding disorders. Detailed examination including abdomen, genitalia, back and skin for evidence of coagulopathy. Medical decision making of low complexity including discussion with patient about diagnostic testing and follow-up.

ACRb: Initial office visit for a 15 year old male, basketball player, with episodic knee swelling following activity.

Description of Pre-Service Work: Preparing to see the patient, reviewing records, and communicating with other professionals as appropriate.

Description of Intra-Service Work: A detailed history, detailed examination, and medical decision making of low complexity.

Description of Post-Service Work: All coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding care plan oversight of more than 30 minutes per month for home health and hospice patients).

SURVEY DATA:

Sample Size: 1074 Response Rate (%): 14% Weighted Median Surveyed RVW: 1.20
25th Percentile RVW: 1.08 75th Percentile RVW: 1.75 Low: 0.40 High: 5.00
Median Pre-Service Time: 5 min Median Intra-Service Time: 24 min
25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 5 High: 60
Median Total Post-Service Time: 24 min
Median Post Service Times For:

Documentation of service provided: 5 min

Arranging for further services: 5 min

Reviewing results of studies: 5 min

Communicating further with patient, family,
and other professionals including reports: 5 min

Providing written or telephone reports to
Medicare or other third party payors: 5 min

Providing care plan oversight services
(less than 30 minutes per month): NA

Has the work of performing this service changed in the past 5 years?

Yes 54% No 46%

The typical complexity of the patient problems being seen in the office has:

Increased 78% Decreased 0% Stayed the Same 22%

The physician work associated with coordination of oversight of care provided by other health professionals has:

Increased 82% Decreased 0% Stayed the Same 18%

The physician work required to document the services provided has:

Increased 87% Decreased 0% Stayed the Same 13%

Do you agree that the Typical Service/Patient provided above describes your typical patient?

Yes 91% No 9%

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	1.07
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	1.81

*indicates presence on MPC

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

are the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) service you are rating to the key reference services listed above.

Compared to reference service 99283, the pre-, intra-, and post-service time of 99203 are greater due to the detailed vs. expanded problem focused history and examination. The mental effort and technical skill are greater for 99203, again due to the extent of the history and examination, while the psychological stress is greater for 99283 because of the intensity of patient care in the emergency situation. This would suggest that the RVW for 99203 be somewhat higher than for 99283. Compared to reference service 12002, the pre, intra, and post service of 99203 are similar or slightly higher. The mental effort of 99203 and 12002 is similar while the increased technical skill and psychological stress are higher for 12002 because of the training and experience needed to repair the wound, and with a wound of this size there is an increased risk for prolonged scarring. This would suggest that the RVW for 99203 be less than the RVW for 12002.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The median surveyed RVW of 1.35, which would be an 18% increase over the current RVW of 1.14 seemed difficult to justify, especially due to the range of median surveyed RVWs by the specialty societies (1.08 - 2.00), and only 54% of respondents indicating that the work of this service has changed over the last 5 years. According to AMA trends analysis, 15.3% of Medicare billing for 99203 were from general/family practice while 10.8% were from internal medicine. In addition, AAFP, ACP, and ASIM had a much smaller spread in surveyed median RVWs (1.37, 1.14, and 1.00 respectively). Therefore, it was felt by the group that a strong argument could be made to increase the RVW to 1.20, which gives more weight to the survey data of AAFP, ACP, and ASIM, and a 5% increase over the current RVW. The rationale for this increase is that pre- and post-service time has increased from the 12 minutes extrapolated by Hsiao to the 29 minutes identified by the survey respondents. An explanation for this may be that Hsiao's extrapolated values do not take into account the extent of post-service work between face-to-face encounters. In addition, over the last 5 years, there has been an increase in the pre and/or post service work due to: increased documentation requirements; increased case management and telephone calls in between face-to-face encounters; and fewer follow-up visits for the same problem. The increased RVW to 1.20 and the increased pre- and post-service time lead to an intra-service intensity of 226 for 99203.

Due to an inconsistency in the survey instrument for the hospital admit, follow-up, and consult codes, the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the office/outpatient visit and consult codes.

Public Comments

06-Jul-95

Code: 99203

1995 RVUs: 1.14

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 3,422,238 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, ACP, ACRh, AGS, ANA, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPM, AAPMR, ACCP, ACEP, ACOG, ACS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99203	41.9	9.5	9.8	60.7	9.8	0.2	0.5	12.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99203	3479328	3615410	1.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99203	0.1	0	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99203	dermatology	7.7
	general surgery	4.7
	general/family practice	15.3
	internal medicine	10.8
	orthopedic surgery	13.6
	otolaryngology	10.9
	podiatry	9.9
	urology	5.3

Public Comments

06-Jul-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99203	401	1.7	ESSENTIAL HYPERTENSION
	715	1.6	OSTEOARTHRITIS AND ALLIED DISORDERS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99203							
ACP		XXX	XXX	1.08	1.14	1.06	1.09

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99203								
ACP	1.16	1.14	1.01	1.06	0.98	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99203								
ACP	XXX	1.08				30		12

Harvard Data:

Comm	Svdimp	Sdvis	Svdadvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99203									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99203									
ACP				INCR	1.14	xx	n		0.026

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 99205 Global Period: XXX Current RVW: 2.28 Recommended RVW: 2.41

CPT Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Source and Summary of Comment to HCFA on this service: AAP, ACP and others.

Increased complexity of patients due to shift from inpatient to outpatient setting over the last 5 - 7 years; increased post-service work over the past 5 - 7 years due to the increased complexity of the patients and prevalence of managed care arrangements, E/M codes thought to be undervalued in general, and especially as compared to non E/M services, and low intra-service intensity of E/M codes as compared to all services studied by Hsiao.

CLINICAL DESCRIPTION OF SERVICE:

Vignettes Used in Survey:

AAP/ACP/AOA/ASIM: Initial outpatient evaluation of a 69 year-old male with severe chronic obstructive pulmonary disease, congestive heart failure, and hypertension. Comprehensive history including extensive as to prior treatment, tests and details needed to seek old records. Comprehensive examination including neurologic exam. Lengthy problem list with plans for new diagnostic testing. Medical decision making of high complexity. Lengthy discussion with patient about multisystem illness severity, prognosis without adequate treatment and follow-up. Counseling including smoking, diet, and medication compliance.

AAP/AOA: Initial office visit for a 5 year old child with a history of a motor vehicle accident at 18 months of age with massive head injury resulting in neurological damage without seizures. A comprehensive history including neurological system, social interaction, and response to previous therapies. A comprehensive examination reveals neurologic deficits. Medical decision making of high complexity and discussion of plans for ongoing management with the family, referrals are made to appropriate community resources, and prescriptions for medications are telephoned to local pharmacists.

ACC: Initial office evaluation of a 65 year-old woman with exertional chest pain, intermittent claudication, syncope and a murmur of aortic stenosis. The physician performs a comprehensive history and comprehensive physical examination including supine and upright blood pressures, vascular system in neck and extremities, heart, neurological system. Medical decision making is of high complexity and involves ordering appropriate diagnostic procedures (electrocardiogram, 2-D and Doppler echocardiography for estimated degree of stenosis and function of ventricle, chest x-ray to check for cardiac hypertrophy and valvular and/or aortic root calcification) and decision regarding hospitalization for cardiac catheterization and coronary angiography and possible head-up tilt table testing. Alternative approaches to diagnosis and therapy are explained to the patient.

ACRb: Initial office evaluation, patient with systemic lupus erythematosus, fever, seizures, and profound thrombocytopenia.

Description of Pre-Service Work: Preparing to see the patient, reviewing records, and communicating with other professionals as appropriate.

Description of Intra-Service Work: A comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Description of Post-Service Work: All coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding call plan oversight of more than 30 minutes per month for home health and hospice patients).

SURVEY DATA:

Specialty: AAFP (50 respondents), AAP (39), ACC (9), ACP (15 general internists, 1 cardiologist, 1 hematologist, and 1 pulmonologist), ACRh (8), AOA (5), ASIM (11 general internists, 3 pulmonologists, 3 gastroenterologists, 2 endocrinologists, 2 allergists, 2 rheumatologists, 1 oncologist, and 1 geriatrician)

Sample Size: 913 Response Rate (%): 14% Median RVW: 2.41

25th Percentile RVW: 2.06 75th Percentile RVW: 2.80 Low: 0.47 High: 6.00

Median Pre-Service Time: 10 min Median Intra-Service Time: 45 min

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 10 High: 90

Median Total Post-Service Time: 55 min

Median Post Service Times For:

Documentation of service provided: 10 min

Arranging for further services: 10 min

Reviewing results of studies: 10 min

Communicating further with patient, family, and other professionals including reports: 11 min

Providing written or telephone reports to Medicare or other third party payors: 5 min

Providing care plan oversight services (less than 30 minutes per month): NA

Has the work of performing this service changed in the past 5 years?

Yes 77% No 23%

The typical complexity of the patient problems being seen in the office has:

Increased 79% Decreased 0% Stayed the Same 21%

The physician work associated with coordination of oversight of care provided by other health professionals has:

Increased 89% Decreased 0% Stayed the Same 11%

The physician work required to document the services provided has:

Increased 94% Decreased 0% Stayed the Same 6%

Do you agree that the Typical Service/Patient provided above describes your typical patient?

Yes 91% No 9%

REFERENCE SERVICE(S):

Code	CPT Descriptor	RVW
	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity.	2.41
43235*	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.39

*indicates presence on MPC

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

As compared to 99220, the pre-, intra-, and post-service times are higher for 99205 because of the required elements of history and examination. The mental effort is greater for 99205 because of expanded differential diagnosis and medical decision making of high complexity, reviewing extended options, extended data and, by definition, the high risk of the procedure. Technical skill and psychological stress are similar for 99220 and 99205. Thus, the RVW for 99205 should be similar to 99220. As compared to 43235, the pre-, intra-, and post-service time are higher for 99205. The mental effort is so greater for 99205. The psychological stress is comparable for 43235 and 99205, while the technical skill is greater for 43235 because of the training, experience and hand-eye coordination needed to provide the procedure. Thus, the RVWs should be similar for 43235 and 99205, with the RVW for 99205 being slightly higher than for 43235.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

There was considerable consistency in the surveyed median RVWs for all specialty societies (2.23 - 2.63) except for Rh (3.25), especially for internal medicine and family physicians (AAFP - 2.32, ACP - 2.63, and ASIM - 2.41) who provide approximately 43% of all of these services to Medicare patients according to AMA trends analysis data. In addition, 77% of respondents identified that this service has changed over the last 5 years. Thus, it was felt that the surveyed median RVW of 2.41 was appropriate for this code. The recommended RVW of 2.41 is a 6% increase over the current RVW of 2.28. The rationale for this increase is that pre- and post-service time has increased from the 23 minutes extrapolated by Hsiao to the 65 minutes identified by the survey respondents. An explanation for this may be that Hsiao's extrapolated values did not take into account the extent of post-service work between face-to-face encounters. In addition, over the last 5 to 7 years, there has been an increase in the pre and/or post service work due to: increased documentation requirements; increased case management and telephone calls in between face-to-face encounters; increased complexity of patients that are seen in the office that would have in the past been seen in the hospital or other facility; and fewer follow-up visits for the same problem. In addition, there is an increase in the complexity and severity of illness of patients seen in the office today as compared to 5 years ago due to a fewer admissions to the hospital and shorter lengths of stay. The greater number of choice and complexity of treatment alternatives, and patients becoming more informed and discerning consumers of health care have increased the physician work involved in office and outpatient settings as well. The increased RVW of 2.41 and increased pre- and post-service time lead to an intra-service intensity of 0.0219 for 99205.

Public Comments

06-Jul-95

Code: 99205

1995 RVUs: 2.28

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 1,449,566 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, ACP, ACRh, AGS, ANA, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPM, AAPMR, ACCP, ACEP, ACOG, ACS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASRM 2, ATS, AUA, RPA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99205	41.2	8.9	13.7	60.6	11	0.3	0.5	6.8

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99205	1577230	1534388	-1.4

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99205	0.1	0	-0.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99205	cardiovascular disease	7.2
	general surgery	3
	general/family practice	11.4
	internal medicine	32.1
	neurology	2.9
	obstetrics/gynecology	4.2
	ophthalmology	6

Public Comments

06-Jul-95

orthopedic surgery	5.4
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Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99205	250	1.7	DIABETES MELLITUS
	366	1.2	CATARACT
	401	4	ESSENTIAL HYPERTENSION
	414	1.7	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
	427	1.1	CARDIAC DYSRHYTHMIAS
	715	1.7	OSTEOARTHRISIS AND ALLIED DISORDERS
	780	1.2	GENERAL SYMPTOMS
	786	1.9	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

	Comm	Modif	Packtrv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99205	ACP		XXX	XXX	2.11	2.28	1.08	2.11

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
99205	ACP	2.30	2.28	1.00	1.09	0.99	1.00	INCR	297

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
99205	ACP	XXX	2.11				60		23

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99205	ACP									

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99205										

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 99211 Global Period: XXX Current RVW: 0.17 Recommended RVW: 0.25

CPT Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

CPT Code: 99212 Global Period: XXX Current RVW: 0.38 Recommended RVW: 0.50

CPT Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

CPT Code: 99214 Global Period: XXX Current RVW: 0.94 Recommended RVW: 1.27

CPT Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Force and Summary of Comment to HCFA on this service: AAFP, AAP, ACP and others.

Increased complexity of patients due to shift from inpatient to outpatient setting over the last 5 - 7 years; increased post-service work over the past 5 - 7 years due to the increased complexity of the patients and prevalence of managed care arrangements, E/M codes thought to be undervalued in general, and especially as compared to non E/M services, and low intra-service intensity of E/M codes as compared to all services studied by Hsiao.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The RVWs for these codes were extrapolated from the surveyed codes within this family of services, 99213 and 99215. In extrapolating, we assumed linear relationships within the family of services. The ratios of pre-service plus post-service time to intra-service time and the calculated intra-service intensities of 99213 and 99215 were used to perform the extrapolation. The intra-service intensities for 99213 and 99215 were calculated using the following formula:

$$\{RVW/[(pre-service + post-service\ time/CPT\ intra-service\ time) + 1]}/CPT\ intra-service\ time.$$

Because of an inconsistency in the survey instrument for the hospital admit, follow-up, and consult codes, the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the office/outpatient visit and consult codes.

Based on the median of the ratios of pre-service plus post-service time to intra-service time and the calculated intra-service intensities of 99213 and 99215, the ratio of pre-service plus post-service time to intra-service time and intra-service intensity were extrapolated to 99211, 99212, and 99214. Once these numbers were available, the RVW was calculated using the above formula.

Public Comments

06-Jul-95

Code: 99211

1995 RVUs: 0.17

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 7,807,529 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, ANA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACRh, ACS, AGS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99211	42.9	8.3	10.2	56.1	9.3	0.3	0.6	14.5

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99211	7111234	7971874	5.9

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99211	0.1	0	0

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99211	cardiovascular disease	5.5
	general surgery	2.8
	general/family practice	22.8
	group practices	3.3
	hematology/oncology	12.7
	internal medicine	21.8
	ophthalmology	2.9
	urology	6.5

Public Comments

06-Jul-95

Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
99211		
185	1.1	MALIGNANT NEOPLASM OF PROSTATE
250	1.4	DIABETES MELLITUS
401	3.3	ESSENTIAL HYPERTENSION

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99211							
ACP		XXX	XXX	0.18	0.17	0.94	0.20

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99211								
ACP	0.19	0.17	1.11	0.95	0.89	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99211								
ACP	XXX	0.18				5		2

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99211									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99211									
ACP				INCR	0.17	xx	n		0.026

Public Comments

06-Jul-95

Code: 99212

1995 RVUs: 0.38

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 29,439,379 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPA, AAPM, ACP, ANA, ASDM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACRh, ACS, AGS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99212	45.5	10.2	10.8	59.3	9.5	0.2	0.5	21.3

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99212	32877773	31266548	-2.5

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99212	0.1	0	0

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99212	dermatology	5.3
	general surgery	4.3
	general/family practice	31.6
	internal medicine	16.9
	ophthalmology	5.8
	orthopedic surgery	5.4
	podiatry	3.8

Public Comments

06-Jul-95

urology	6.1
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Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99212	250	1.6	DIABETES MELLITUS
	401	3.2	ESSENTIAL HYPERTENSION
	715	1	OSTEOARTHRITIS AND ALLIED DISORDERS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99212							
ACP		XXX	XXX	0.38	0.38	1.00	0.38

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99212								
ACP	0.39	0.38	1.00	1.03	0.97	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
99212								
ACP	XXX	0.38				10		4

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
99212									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99212									
ACP				INCR	0.38	xx	n		0.027

Public Comments

06-Jul-95

Code: 99214

1995 RVUs: 0.94

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 28,381,486 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPA, AAPM, ACP, ANA, ASDM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACRh, ACS, AGS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA, RPA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99214	47.5	10.9	11.7	61.7	8.7	0.3	0.6	8.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99214	25646495	29436020	7.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99214	0.1	0	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99214	cardiovascular disease	9.3
	general/family practice	19.5
	group practices	2.9
	hematology/oncology	5.3
	internal medicine	29.2
	ophthalmology	4.6
	pulmonary disease	2.7

Public Comments

06-Jul-95

rheumatology	2.7
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Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99214			
	250	2.4	DIABETES MELLITUS
	272	1.3	DISORDERS OF LIPOID METABOLISM
	401	4.4	ESSENTIAL HYPERTENSION
	414	2.2	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
	427	1.3	CARDIAC DYSRHYTHMIAS
	428	1.1	HEART FAILURE
	715	1.3	OSTEOARTHRITIS AND ALLIED DISORDERS
	786	1.1	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99214							
ACP		XXX	XXX	0.87	0.94	1.08	0.88

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99214								
ACP	0.96	0.94	1.01	1.09	0.98	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99214								
ACP	XXX	0.87				25		10

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99214									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99214									

Public Comments

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ACP	INCR	0.94	xx	n	0.026
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FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

PT #: 99213 Global Period: XXX Current RVW: 0.55 Recommended RVW: 0.80

PT Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Source and Summary of Comment to HCFA on this service: AAFP, AAP, ACP and others.

Increased complexity of patients due to shift from inpatient to outpatient setting over the last 5 - 7 years; increased post-service work over the past 5 - 7 years due to the increased complexity of the patients and prevalence of managed care arrangements, E/M codes thought to be undervalued in general, and especially as compared to non-E/M services, and low intra-service intensity of E/M codes as compared to all services studied by Hsiao.

CLINICAL DESCRIPTION OF SERVICE:

Vignettes Used in Survey:

AAFP/AAPA/ACP/ANA/AOA/ASIM: Office visit with 55 year-old male, established patient, for management of hypertension, mild fatigue, on beta blocker/thiazide regimen. Expanded problem focused history including compliance, diet, stress issues. Expanded problem focused exam including vital signs, chest and heart exam; check for edema. Medical decision making of low complexity including counseling about medication and alternatives, appropriate lab work, and a review of possible medication side effects.

AAFP: Office visit for an established 3 year old female patient with a two day history of ear pain, fever, cough, and inability to sleep at night. Expanded problem focused history including labored breathing, characteristics of pain, respiratory system. Expanded problem focused examination including ears, nose, throat, chest, and hydration status. Medical decision making of low complexity and discussions regarding tonsillectomy and adenoidectomy and a follow-up visit with her mother. Antibiotics are prescribed.

AAPM: Office visit for reassessment and reassurance/counseling of a 40 year old female, established patient, who is experiencing increased symptoms while on a pain management treatment program. Physician performs an expanded problem focused history and problem focused physical examination of new or increased symptoms. Medical decision making is of low complexity in determining if additional somatic pain management, pharmacologic interventions/adjustment, behavioral pain management strategies, or physical therapy and rehabilitation interventions are needed. Reassurance and counseling is higher intensity in patients with pain due to the frequent occurrence of severe distress, confrontational attitudes, and litigious nature of the initial injury or failed responses to treatment.

ACC: Office visit for a 56 year-old man, established patient, with stable exertional angina who complains of new onset calf pain while walking. The physician performs an expanded problem focused history and expanded problem focused physical examination including the entire vascular system, especially the appearance of the legs supine and when dependent. Medical decision making is of low complexity and involves ordering Doppler test of legs and initiating appropriate medical therapy. Alternative approaches to diagnosis and therapy are explained to the patient.

ACRn: Follow-up visit with 80 year old female established patient for follow-up osteoporosis, status-post compression fractures.

Description of Pre-Service Work: Preparing to see the patient, reviewing records, and communicating with other professionals as appropriate.

Description of Intra-Service Work: An expanded problem focused history, an expanded problem focused examination, and medical decision making of low complexity.

Description of Post-Service Work: All coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding care plan oversight of more than 30 minutes per month for home health and hospice patients).

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	9282*	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	0.47
2)	45330*	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	0.70

*indicates presence on MPC

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Compared to 99282, pre-, intra-, and post-service times and mental effort are higher for 99213 because the history, examination and medical decision making are all at a higher level of complexity. Technical skill is equivalent for 99213 and 99283, while 99283 involves more psychological stress because of the acuteness of the emergency department patient. This suggests that the RVW for 99213 should be significantly greater than that of 99282. As compared to 45330, 99213 requires more mental effort, psychological stress, and time, while 45330 involves more psychological stress due to the complexity of the procedure and the small, but real risk of perforation. This suggests that the RVW for 99213 should be similar, but somewhat higher than the RVW for 45330.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The median surveyed RVW of 1.00, which would be an 81% increase over the current RVW of 0.55, seemed difficult to justify, especially due to the range of median surveyed RVWs by the specialty societies (0.47 - 1.50), and only 56% of respondents indicating that the work of this service has changed over the last 5 years. According to AMA trends analysis, 29.7% of Medicare billing for 99213 were from general/family practice while 30.3% were from internal medicine. In addition, AAFP, ACP, and ASIM had a much smaller spread in surveyed median RVWs (1.00, 1.00, and 0.53 respectively). Therefore, it was felt by the group that a strong argument could be made to increase the RVW to 0.80, which gives more weight to the survey data of AAFP, ACP, and ASIM, and a 45% increase over the current RVW. The rationale for this increase is that pre- and post-service time has increased from the 6 minutes extrapolated by Hsiao to the 21 minutes identified by the survey respondents. An explanation for this may be that Hsiao's extrapolated values did not take into account the extent of post-service work between face-to-face encounters. In addition, over the last 5 to 7 years, there has been an increase in the pre and/or post service work due to: increased documentation requirements; increased case management and telephone calls in between face-to-face encounters; and fewer follow-up visits for the same problem. In addition, there is an increase in the complexity and severity of illness for patients seen in the office today as compared to 5 years ago due to a fewer admissions to the hospital and shorter lengths of stay. The greater number of choice and complexity of treatment alternatives, and patients becoming more informed and discerning consumers of health care have increased the physician work involved in office and outpatient services as well. and telephone calls in between face-to-face encounters; and fewer follow-up visits for the same problem. The increased RVW of .80 and increased pre- and post-service time lead to an intra-service intensity of 0.0222 for 99213.

SURVEY DATA:

per AAFP (50 respondents), AAP (26), AAPA (25), AAPM (21), ACC (9), ACP (10 general internists and 3
pediatric logists), ACRh (10), ANA (26), AOA (2), ASIM (11 general internists, 3 pulmonologists, 3 gastroenterologists,
endocrinologists, 2 allergists, 2 rheumatologists, 1 oncologist, and 1 geriatrician)

Sample Size: 1203 Response Rate (%): 15% Weighted Median Surveyed RVW: 0.80

5th Percentile RVW: 0.56 75th Percentile RVW: 1.34 Low: 0.05 High: 4.50

Median Pre-Service Time: 5 min Median Intra-Service Time: 15 min

5th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 15 Low: 5 High: 45

Median Total Post-Service Time: 16 min

Median Post Service Times For:

Documentation of service provided: 5 min

Arranging for further services: 2 min

Reviewing results of studies: 3 min

Communicating further with patient, family,
and other professionals including reports: 5 min

Providing written or telephone reports to
Medicare or other third party payors: 2 min

Providing care plan oversight services
(less than 30 minutes per month): NA

Has the work of performing this service changed in the past 5 years?

Yes 56% No 44%

The typical complexity of the patient problems being seen in the office has:

Increased 62% Decreased 0% Stayed the Same 38%

The physician work associated with coordination of oversight of care provided by other health professionals has:

Increased 77% Decreased 0% Stayed the Same 23%

The physician work required to document the services provided has:

Increased 84% Decreased 0% Stayed the Same 16%

Do you agree that the Typical Service/Patient provided above describes your typical patient?

Yes 92% No 8%

Public Comments

06-Jul-95

Code: 99213

1995 RVUs: 0.55

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 77,962,473 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPA, AAPM, ACP, ACRh, AGS, ANA, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99213	47.7	11.1	10.6	61	8.3	0.2	0.4	15.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99213	77700985	81738355	2.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99213	0.1	0	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99213	cardiovascular disease	5.8
	general/family practice	29.7
	group practices	3.5
	hematology/oncology	2.4
	internal medicine	30.3
	ophthalmology	3.7
	orthopedic surgery	2.4

Public Comments

06-Jul-95

urology	3.2
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Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
99213		
250	2.4	DIABETES MELLITUS
272	1.2	DISORDERS OF LIPOID METABOLISM
401	4.9	ESSENTIAL HYPERTENSION
414	1.8	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
715	1.3	OSTEOARTHRITIS AND ALLIED DISORDERS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99213							
ACP		XXX	XXX	0.53	0.55	1.04	0.54

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
99213								
ACP	0.57	0.55	1.02	1.06	0.96	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99213								
ACP	XXX	0.53				15		6

Harvard Data:

Comm	Svdimp	Sdvis	Svdadvis	Sdvisdur	Hvis	Svdhvis	Hviedur	Icvis	Offvis
99213									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99213									
ACP				INCR	0.55	xx	n		0.027

FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

PT # [redacted] File: 99215 Global Period: XXX Current RVW: 1.51 Recommended RVW: 1.90

PT Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Source and Summary of Comment to HCFA on this service: AAFP, AAP, ACP, ASIM and others.

Increased complexity of patients due to shift from inpatient to outpatient setting over the last 5 - 7 years; increased post-service work over the past 5 - 7 years due to the increased complexity of the patients and prevalence of managed care arrangements, E/M codes thought to be undervalued in general, and especially as compared to non E/M services, and low intra-service intensity of E/M codes as compared to all services studied by Hsiao.

CLINICAL DESCRIPTION OF SERVICE:

Cigarettes Used in Survey:

AAFP/ACP/AOA/ASIM: Office visit with 30 year old male, established patient for 3 month history of fatigue, weight loss, intermittent fever, and presenting with diffuse adenopathy and splenomegaly. Comprehensive history including complaints and possible exposure such as sexual, travels abroad, etc. Comprehensive exam including lymphatic and abdominal. Medical decision making of high complexity including discussion of possible diagnosis, possible diagnostic test needed and importance of follow-up.

AAFP: An 8 year old established patient is seen for a history of continued fighting in school. Comprehensive interval history including physical performance, peer relationships, family interactions, and family history of ADHD. A comprehensive physical examination reveals only soft neurological signs. Medical decision making of high complexity and discussion on behavior modification and Connors questionnaires are undertaken with parents. A return visit is scheduled.

AAFP: Office visit for an established patient having acute migraine with new onset neurological symptoms and whose headaches are unresponsive to previous attempts at management with a combination of preventive and abortive medication. Physician performs a comprehensive history and a comprehensive physical examination, as well as a complete neurological exam. Examination of the head and neck is accomplished to detect extracranial sources of myofascial or neurogenic pain. Medical decision making is of high complexity and involves ordering new imaging studies. A new treatment plan is formulated with pharmacologic adjustments and behavioral pain management strategies.

AAFP: Office visit for a 68 year-old man with previous prosthetic valve replacement, diabetes and morbid obesity who now presents with new onset dyspnea and fluid retention. The physician performs a comprehensive history and comprehensive physical examination including heart, lungs and abdomen, venous system in neck and legs while lying, sitting and standing, skin and soft tissue of legs. Fluid restriction, diet and therapeutic goals are discussed with the patient. Medical decision making is of high complexity and involves ordering chest x-ray and echocardiogram to assess valvular function, lab work to evaluate control of diabetes and renal function, and initiating appropriate medical therapy.

AAFP: Follow-up visit, 40 year old mother of three, established patient, with acute rheumatoid arthritis, anatomical Stage 3, ARA function Class 3 rheumatoid arthritis, and deteriorating function.

Description of Pre-Service Work: Preparing to see the patient, reviewing records, and communicating with other professionals as appropriate.

Description of Intra-Service Work: A comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Description of Post-Service Work: All coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding care plan oversight of more than 30 minutes per month for home health and hospice patients).

SURVEY DATA:

Specialty: AAFP (50 respondents), AAP (39), AAPM (21), ACC (9), ACP (10 general internists and 3 nephrologists), ACRh (15), AOA (5), ASIM (11 general internists, 3 pulmonologists, 3 gastroenterologists, 2 endocrinologists, 2 allergists, 2 rheumatologists, 1 oncologist, and 1 geriatrician)

Sample Size: 967 Response Rate (%): 16% Weighted Median Surveyed RVW: 1.90

25th Percentile RVW: 1.60 75th Percentile RVW: 2.41 Low: 0.70 High: 4.00

Median Pre-Service Time: 5 min Median Intra-Service Time: 35 min

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 45 Low: 7 High: 90

Median Total Post-Service Time: 42 min

Median Post Service Times For:

Documentation of service provided: 10 min

Arranging for further services: 10 min

Reviewing results of studies: 10 min

Communicating further with patient, family, and other professionals including reports: 10 min

Providing written or telephone reports to Medicare or other third party payors: 5 min

Providing care plan oversight services less than 30 minutes per month): NA

Has the work of performing this service changed in the past 5 years?

Yes 74% No 26%

The typical complexity of the patient problems being seen in the office has:

Increased 80% Decreased 0% Stayed the Same 20%

The physician work associated with coordination of oversight of care provided by other health professionals has:

Increased 86% Decreased 0% Stayed the Same 14%

The physician work required to document the services provided has:

Increased 90% Decreased 0% Stayed the Same 10%

Do you agree that the Typical Service/Patient provided above describes your typical patient?

Yes 92% No 8%

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity.	2.41
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	1.81

*indicates presence on MPC

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

As compared to 99220, pre-, intra-, and post-service times and mental effort are similar for 99215 due to the increased requirement for counseling and coordination of care in the office as compared to the observation area. 99215 involves similar technical skill and psychological stress as 99220. The RVW for 99215 should be lower than for 99220. As compared to 12002, 99215 requires more mental effort and time, but less psychological stress than 12002 due to the nature of the wound and the potential for poor outcome with inappropriate technique. The technical skill for these services is similar. Thus the RVW for 99215 should be similar to but higher than the RVW for 12002.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The median surveyed RVW of 2.00, which would be a 32% increase over the current RVW of 1.51, seemed difficult to justify, especially due to the range of median surveyed RVWs by the specialty societies (1.83 - 2.40). According to the AMA trends analysis, 19.5 % of Medicare billing for 99215 were from general/family practice while 36% were from internal medicine. In addition, AAFP, ACP, and ASIM had a much smaller spread in surveyed median RVWs (1.80, 2.00, and 2.10 respectively). Therefore, it was felt by the group that a strong argument could be made to increase the RVW to 1.90; which gives more weight to the survey data of AAFP, ACP, and ASIM, and a 26% increase over the current RVW. The rationale for this increase is that pre- and post-service time has increased substantially from the 15 minutes extrapolated by Hsiao to the 47 minutes identified by the survey respondents. An explanation for this may be that Hsiao's extrapolated values did not take into account the extent of post-service work between face-to-face encounters. In addition, over the last 5 to 7 years, there has been an increase in the pre and/or post service work due to: increased documentation requirements; increased case management and telephone calls in between face-to-face encounters; and fewer follow-up visits for the same problem. In addition, there is an increase in the complexity and severity of illness for patients seen in the office today as compared to 5 years ago due to a fewer admissions to the hospital and shorter lengths of stay. The greater number of choice and complexity of treatment alternatives, and patients becoming more informed and discerning consumers of health care have increased the physician work involved in office and outpatient services as well, and telephone calls in between face-to-face encounters; and fewer follow-up visits for the same problem. The increased RVW and increased pre- and post-service time lead to an intra-service intensity of 0.0231 for 99215.

Public Comments

06-Jul-95

Code: 99215

1995 RVUs: 1.51

Recommended RVUs: 2.42

Ratio:

Long Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 6,255,193 **Impact:** 5692226

Source: 7 **Year:** 93 **Public Comment Letter:** 321

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, ACRh, AGS, ANA, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99215	44.6	9.6	10.3	61.3	8.2	0.3	0.5	8.3

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99215	5906383	6423896	4.3

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99215	0.1	0	-0.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99215	cardiovascular disease	6.2
	general/family practice	19.5
	group practices	3
	hematology/oncology	3.3
	internal medicine	36
	neurology	2.6
	obstetrics/gynecology	3.4

Public Comments

06-Jul-95

ophthalmology

6.1

Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
99215		
250	2	DIABETES MELLITUS
272	2.4	DISORDERS OF LIPOID METABOLISM
366	1.2	CATARACT
401	5.2	ESSENTIAL HYPERTENSION.
414	2.2	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	1.5	CARDIAC DYSRHYTHMIAS
715	1.7	OSTEOARTHRISIS AND ALLIED DISORDERS
786	1.5	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhrv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99215							
ACP		XXX	XXX	1.38	1.51	1.09	1.38
ASIM		XXX	XXX	1.38	1.51	1.09	1.38

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99215								
ACP	1.53	1.51	1.00	1.11	0.99	1.00	INCR	297
ASIM	1.53	1.51	1.00	1.11	0.99	1.00	2.42	321

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99215								
ACP	XXX	1.38				40		15
ASIM	XXX	1.38				40		15

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99215									
ACP									

Public Comments

06-Jul-95

ASIM

Harvard Data:

Comm	Svdoffd	Offvdr	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99215									
ACP				INCR	1.51	xx	n		0.026
ASIM				2.42	1.51	xx	n		0.026

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 99231 Global Period: XXX Current RVW: 0.51 Workgroup Recommended RVW: 0.60

CPT Descriptor: Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

1. a problem focused interval history;
2. a problem focused examination; and
3. medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has also increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Subsequent hospital visit for a 50 year old male with uncomplicated myocardial infarction who is clinically stable and without chest pain. (ASIM/ACP/AQA/ACC)

Subsequent hospital visit for a 4 year old female, admitted for acute gastroenteritis and dehydration, requiring IV hydration; now stable. (AAFP/AQA/AAPA)

Subsequent hospital visit for a 10 year old male admitted with right upper lobe pneumonia, vomiting and 8 percent dehydration. (AAP/AQA)

Subsequent hospital visit for a 55 year old male with rheumatoid arthritis, two days following an uncomplicated joint replacement. (ACR)

Description of Pre-Service Work:

Pre-service work includes preparing to see the patient, reviewing records, and communicating with other professionals, as appropriate. (ALL)

Description of Intra-Service Work:

Problem focused interval history including cardiopulmonary systems and extremities. Problem focused examination including evaluation for congestive heart failure and arrhythmias. (ASIM/ACP/AQA)

The physician performs a problem focused interval history and problem focused physical examination including history of chest discomfort, dyspnea and present energy level. Medical decision making is of moderate complexity including instruction on increased activity and return to work and titrating medications to optimal doses and ordering or evaluating the results of functional testing. (ACC)

Problem focused interval history including P.O. intake, total input and output, and bowel habits since admission. Problem focused exam including abdomen and skin turgor. Medical decision making of low complexity including discussion of progress and plans with patient and responsible caregiver. (AAFP/AQA/AAPA)

He continues on intravenous fluids, begins to deconvalesce, and begins to tolerate oral fluids. Examination reveals improved hydration, less work of breathing, decreasing rales and rhonchi in the right lung field, and a more interactive patient. His blood culture is checked and continues without growth. His condition is discussed with his family and the bedside nurse. Discharge is anticipated the following day if oral intake improves. (AAP/AQA)

Intake and output are checked and laboratory values are reviewed. Orders from the orthopedist are reviewed for accuracy and appropriateness. Medications are reviewed and appropriate medications are resumed. A focused examination of the heart and lungs is performed. A brief assessment of range of motion is also performed. (ACR)

Post-service work includes all coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals, associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding care plan oversight of more than 30 minutes per month for home health and hospice patients). (ALL)

SURVEY DATA:

Specialty: Combined data: American Society of Internal Medicine, American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association, American College of Cardiology, American College of Rheumatology, and American Academy of Physician Assistants

Sample Size: 164/947 Response Rate (%): 17% Weighted Median RVW: 0.75

25th Percentile RVW: 0.55 75th Percentile RVW: 1.19 Low: 0.25 High: 3.8

Median Pre-Service Time: 5 minutes Median Intra-Service Time: 10 minutes

25th Percentile Intra-Svc Time: 10 minutes 75th Percentile Intra-Svc Time: 15 minutes

Low Intra-Svc Time: 2.5 minutes High Intra Svc Time: 90 minutes

Median Post-Service Time: 21 minutes

Elements of Post Time:

Median time for documentation of the service provided: 5 minutes

Median time for arranging for further services: 4 minutes

Median time for reviewing results of studies: 4 minutes

Median time for communicating further with patient, family, and other professionals including reports: 5 minutes

Median time for providing written or telephone reports to Medicare or other third party payers: 3 minutes

Median time for providing care plan oversight services less than 30 minutes per month: X minutes *

* Care plan oversight was not included on most survey reporting forms.

Work Changed?: Complexity: Increased: 79.3% Decreased: 3.3% Same: 17.4%

Oversight: Increased: 81% Decreased: 2% Same: 17%

Documentation: Increased: 87.1% Decreased: 0% Same: 12.9%

Vignette Typical?: Yes: 88.9% No: 11.1%

Demographics (who responded): General internists: 36 Family physicians: 47

Pediatricians: 37 Physician Assistants: 7 Internal Medicine Subspecialists: 37

Breakdown by Subspecialty: Cardiology 10, Rheumatology 13, Endocrinology 2, Pulmonology 3, Allergy 2, Gastroenterology 2, Nephrology 3, Infectious Disease 1, Hematology 1.

KEY REFERENCE SERVICE(S):

CPT Code 99231

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99282	Emergency Dept Visit	0.47
2)	20610	Drain/Inject Joint/Bursa	0.79

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

According to the survey results, mental effort, technical skill and psychological stress were rated about the same for 99282 and 99231. Pre- and post time for 99231 were estimated to be somewhat higher. This is because the typical less-complex emergency department patient is similar to a "stable" (lowest level) subsequent hospital visit patient. However, the post service time involved with the hospital patient is higher because the hospital patient will have more tests results to be reviewed, and more coordination and follow-up of care is required. Pre-time for the subsequent hospital visit is higher because the physician has seen the previously and the chart will be reviewed whereas the typical emergency department patient does not involve much if any pre-service work.

Compared to 20610, 99231 was rated by survey respondents as slightly higher in mental effort, psychological stress, intra time and post time, but slightly lower in technical skill and pre time. The technical skill of properly draining or injecting a joint or a bursa may be slightly higher than the lowest level subsequent hospital visit, but as the survey respondents indicated, the mental effort of assessing the hospital patient's status, the stress involved with making treatment decisions and the time on the hospital unit are higher than for a joint injection. There isn't much post service time involved with the procedure whereas there is significant post-service time involved with the hospital visit as hospital care must be coordinated, and as reports must be documented and communicated.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The surveying organizations recommend an increase in RVWs to 0.75, even though the median of the combined survey results was much higher (1.0 RVWs). The combined survey median "total time estimate" of 36 minutes is substantially higher than the current 18 minutes of total time assumed for this code. The intra-service combined median time of 10 minutes is slightly below the current intra-service time of 15 minutes and post-service time is substantially higher than the 3 minutes that is currently assumed in the RVWs. If some of the post-service time was shifted to intra-time to correct for the inconsistency in the survey instrument, the result would be an intra-service time that is the same or higher than is currently assumed, and post-service time would still be substantially higher.

In regard to the clinical example and vignette used by ASIM, ACP, and AOA, the typical post-MI patient care is accelerated as compared to the same patient five years ago. The amount of physician work is compressed into a shorter patient hospital stay. Instead of rest and gradual activity for the stable hospital patient, frequent interventions are common. Today, more information and treatment options are integrated by the physician into the treatment plan. Discussion with the patient and family are typically more complex than five years ago as issues of diet and cholesterol management and the use of various medications are discussed with the patient and family. All different factors require complex coordination of care by the physician on behalf of the patient.

An increase in post-service time and work has taken place over the past five years due to a compression of hospital stays and more education of patients and family members provided during each hospital visit. The hospital stay now requires that more data be analyzed and pursued during each visit. Less ill patients are also likely to already have been discharged, meaning that the patients that are being seen under this code are sicker.

These patients also on average have more co-morbidities than was the case in the past. Data gathered from the HCFA *Health Care Financing Review* indicates that hospital length of stay has decreased 10.1 percent for Medicare beneficiaries during the five year period of 1988 to 1993 (from 8.9 to 8.0). The hospital discharge rate

has decreased 1.6 percent during the same period (from 316 per 1000 enrollees to 311).

Because of the inconsistency in the survey instrument (see "rationale" of CPT Code 99223), the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the hospital visit and consult codes.

Public Comments

06-Jul-95

Code: 99231 1995 RVUs: 0.51 Recommended RVUs: Inc Ratio:

Long Descriptor: Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n): Y Global Period: XXX Frequency: 27,190,916 Impact:
 Source: 7 Year: 93 Public Comment Letter: 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPA, AAPM, ACP, ACRh, AGS, AOA, ASIM
Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACOG, ACS, ANA, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99231	57.7	19.7	14.3	57.4	10.2	0.6	2	15

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99231	37034587	31825462	-7.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99231	98.3	96.4	-1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99231	cardiovascular disease	9.8
	gastroenterology	4.4
	general/family practice	16.7
	group practices	4.1
	internal medicine	30.4
	neurology	3.5
	pulmonary disease	5.2

Public Comments

06-Jul-95

rehabilitation medicine	6.6
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Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
99231		
250	2.2	DIABETES MELLITUS
276	1.6	DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE
401	2	ESSENTIAL HYPERTENSION
414	1.8	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	1.7	CARDIAC DYSRHYTHMIAS
428	2.6	HEART FAILURE
486	1.6	PNEUMONIA, ORGANISM UNSPECIFIED
496	1.5	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED

Harvard Data:

Comm	Modif	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99231						
ACP		XXX	0.52	0.51	0.98	0.54
ASIM		XXX	0.52	0.51	0.98	0.54

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99231								
ACP	0.54	0.51	1.04	1.00	0.94	1.00	INCR	297
ASIM	0.54	0.51	1.04	1.00	0.94	1.00	0.97	321

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
99231								
ACP	XXX	0.52				15		3
ASIM	XXX	0.52				15		3

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99231									
ACP									

Public Comments

06-Jul-95

ASIM

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99231									
ACP				INCR	0.51	xx	n		0.031
ASIM				0.97	0.51	xx	n		0.031

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 99232 Global Period: XXX Current RVW: 0.88 Workgroup Recommended RVW: 1.10

CPT Descriptor: Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

1. an expanded problem focused interval history;
2. an expanded problem focused examination; and
3. medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has also increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Subsequent hospital visit for a 54 year old female, post myocardial infarction, who is out of the critical care unit, but is now having frequent premature ventricular contractions on telemetry. (ASIM/ACPI/AOA)

Subsequent hospital visit for a 54 year old female admitted for myocardial infarction, but who now having frequent premature ventricular contractions. (AAFP/AOA)

Subsequent hospital visit for a 17 year old female admitted with fever and pharyngitis with airway obstruction. (AAP/AOA)

Follow-up hospital visit for a 54-year-old patient, post-myocardial infarction who is out of the coronary care unit, but now having recurring chest pain. (ACC)

Subsequent hospital visit for a 65 year old female with rheumatoid arthritis, anatomical stage 3, ARA function class 3 rheumatoid arthritis, admitted for trosepsis. On the third hospital day, chest pain, dyspnea, and fever develop. (ACR)

Description of Pre-Service Work:

Pre-service work includes preparing to see the patient, reviewing records, and communicating with other professionals, as appropriate. (ALL)

Description of Intra-Service Work:

Expanded problem focused interval history, including review of events since admission, focused on cardiopulmonary systems. Expanded problem focused interval exam including heart, lungs, extremities. Medical decision making of moderate complexity including review of all test results, x-rays, rhythm strips, medication adjustments and a plan for more extensive cardiovascular work-up. (ASIM/ACPI/AAFP/AOA)

Her fever is now decreasing after 48 hours of antibiotics. However she has developed a generalized maculopapular eruption preeminently on her trunk. She had been maintained on intravenous antibiotics and is now ready for oral liquids. Review of laboratory data reveals a positive group A beta hemolytic streptococcus on throat culture and a leukocytosis. Her condition is discussed with her parents and a bedside nurse. (AAP/AOA)

The physician performs an expanded problem focused interval history and expanded problem focused physical examination including heart, lungs, blood pressure and cardi-rhythm. Alternative approaches to diagnosis and therapy are explained to the patient. Medical decision making is of moderate complexity and involves decision regard stress testing, cardiac catheterization and possible angioplasty, ordering lab work to assess recurrent infarction, and reviewing current medications. (ACC)

A detailed history of the hospital course is obtained through interviews and review of the hospital record. Careful examination of the heart, lung, and extremities is performed. A ventilation/perfusion study and EKG are reviewed and a treatment course is instituted. (ACR)

Post-service work includes all coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals, associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding care plan oversight of more than 30 minutes per month for home health and hospice patients). (ALL)

SURVEY DATA:

Specialty: Combined data: American Society of Internal Medicine, American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association, American College of Cardiology, and American College of Rheumatology

Sample Size: 153/937 Response Rate (%): 16% Weighted Median RVW: 1.3

25th Percentile RVW: 1.1 75th Percentile RVW: 2.0 Low: 0.47 High: 4.42

Median Pre-Service Time: 7 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 25 minutes

Low Intra-Svc Time: 2 minutes High Intra-Svc Time: 90 minutes

Median Post-Service Time: 35 minutes

Elements of Post Time:

Median time for documentation of the service provided: 5 minutes

Median time for arranging for further services: 5 minutes

Median time for reviewing results of studies: 5 minutes

Median time for communicating further with patient, family, and other professionals including reports: 10 minutes

Median time for providing written or telephone reports to Medicare or other third party payers: 5 minutes

Median time for providing care plan oversight services less than 30 minutes per month: X minutes*

* Care plan oversight was not included on most survey reporting forms.

Work Changed?: Complexity: Increased: 85.2% Decreased: 0% Same: 14.8%

Oversight: Increased: 85.2% Decreased: 0% Same: 14.8%

Documentation: Increased: 90.7% Decreased: 0% Same: 9.3%

Vignette Typical?: Yes: 89.7% No: 10.3%

Demographics (who responded):

General internists: 36 Family physicians: 47 Pediatricians: 37

Internal Medicine Subspecialists: 33

Breakdown by Subspecialty: Cardiology 10, Rheumatology 9, Hematology 1, Endocrinology 2, Pulmonology 3, Allergy 2, Gastroenterology 2, Nephrology 3, Infectious Disease 1.

Handwritten notes: 20, 35, 7, 62

KEY REFERENCE SERVICE(S):

CPT Code 99232

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99283	Emergency Dept Visit	1.07
2)	62270	Spinal Fluid Tap, Diagnostic	1.13

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Compared to reference service 99283 (ER visit, moderate severity), CPT 99232 has similar mental effort, technical skill and stress and pre-time and intra-time, but a higher post time. This would argue for a substantial increase in the RVWs for CPT 99232. The survey respondents compared these services in that manner because the MI patient with potentially unstable arrhythmia will need much more after-visit followup to check on test results and to modify treatment than the typical ER visit patient.

CPT 62270 and 99232 were rated by survey respondents to have comparable mental effort, technical skill and stress. Pre- and intra-time are also comparable, and post-time is substantially higher for CPT 99232. The MI patient requires similar effort and skill to sort through the problem and causes a similar amount of stress as the spinal tap, but the MI patient with potentially unstable arrhythmia will need much more after-visit followup to check on test results and to modify treatment than the spinal tap patient.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale including materials you received from the AMA or your own research.

The surveying organizations recommend an increase in the RVWs to 1.30. The survey data supports an even larger increase—the combined median RVW is much higher (1.5). Total time reported by all specialties is significantly higher than the 29 minutes total time assumed in the current RVWs—the median combined total time is 62 minutes. Increased coordination of care, increased communication with family members and the compression of patients' hospital stays support the view the post-service time is significantly higher than accounted for in the current RVWs.

In regard to the clinical example and vignette used by ASIM, ACP, AAFP, and AOA, physicians are more aggressive in their treatment of coronary disease, and the decision making required to decide when and how to intervene on a PVC patient is much more complex than five years ago. This is because there is a greater variety of treatment options, such as IV infusions, newer-more toxic drugs. This requires more time to assess the patient, to discuss treatment options with the patient and her family, to coordinate with the consultant (if there is one), and to plan further treatment.

Because of the inconsistency in the survey instrument (see "rationale" of CPT Code 99223), the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the hospital visit and consult codes.

Public Comments

06-Jul-95

Code: 99232

1995 RVUs: 0.88

Recommended RVUs: Inc

Ratio:

Long Descriptor: Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n): Y Global Period: XXX Frequency: 31,480,324 Impact:

Source: 7 Year: 93 Public Comment Letter: 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPA, AAPM, ACP, ACRh, ANA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACOG, ACS, AGS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99232	57.5	19.6	14.5	56.4	9.3	0.8	2.5	11.3

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99232	33871442	36152997	3.3

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99232	98.9	98.2	-0.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99232	cardiovascular disease	13
	gastroenterology	3.3
	general/family practice	14.3
	group practices	3.5
	hematology/oncology	3.8
	internal medicine	33.5

Public Comments

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nephrology	4
pulmonary disease	8.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99232			
	250	2.2	DIABETES MELLITUS
	276	1.8	DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE
	401	2	ESSENTIAL HYPERTENSION
	414	2.1	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
	427	2.2	CARDIAC DYSRHYTHMIAS
	428	3.3	HEART FAILURE
	486	1.8	PNEUMONIA, ORGANISM UNSPECIFIED
	496	1.7	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99232								
	ACP		XXX	XXX	0.86	0.88	1.02	0.88
	ASIM		XXX	XXX	0.86	0.88	1.02	0.88

Harvard Data:

	Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99232									
	ACP	0.91	0.88	1.02	1.03	0.97	1.00	INCR	297
	ASIM	0.91	0.88	1.02	1.03	0.97	1.00	138	321

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99232									
	ACP	XXX	0.86				25		4
	ASIM	XXX	0.86				25		4

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99232										
	ACP									

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ASIM

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99232									
ACP				INCR	0.88	xx	n		0.030
ASIM				1.38	0.88	xx	n		0.030

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 99233 Global Period: XXX Current RVW: 1.25 Workgroup Recommended RVW: 1.56

CPT Descriptor: Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

1. a detailed interval history;
2. a detailed examination; and
3. medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has also increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This service was not surveyed directly for the five year review. Our recommendation for this service is based upon the intra-service intensity that was found for the other two codes in this family of service (99231 and 99232).

The surveying organizations recommend an increase in the RVWs to 1.75. Based upon the survey results for the other two services in this family, we believe that the total time associated with this service has increased. Increased coordination of care, increased communication with family members and the compression of patients' hospital stays support the view the post-service time is significantly higher than accounted for in the current RVWs.

Because of the inconsistency in the survey instrument (see "rationale" of CPT Code 99223), the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the hospital visit and consult codes.

Specialty: Calculated data: American Society of Internal Medicine, American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association, American College of Cardiology, American College of Rheumatology, American Academy of Neurology, American Academy of Pain Medicine, American Geriatrics Society, American Nurses Association, and American Academy of Physician Assistants

Public Comments

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Code: 99233

1995 RVUs: 1.25

Recommended RVUs: Inc

Ratio:

Long Descriptor: Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 10,374,439 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPA, AAPM, ACP, AGS, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACOG, ACRh, ACS, ANA, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCO, ASCRS, ASRM 2, ATS, AUA

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99233	54.4	17.3	14.8	54.5	11	0.8	2.3	8.8

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
99233	9746124	11741992	9.8

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99233	98.5	97.4	-0.5

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
99233	cardiovascular disease	15.4
	general/family practice	10.9
	group practices	3
	hematology/oncology	3.8
	internal medicine	31.7
	nephrology	3.8
	psychiatry	5.7

Public Comments

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pulmonary disease	10.4
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Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
99233		
250	2	DIABETES MELLITUS
276	1.7	DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE
401	1.8	ESSENTIAL HYPERTENSION
414	2.2	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	2.6	CARDIAC DYSRHYTHMIAS
428	3.6	HEART FAILURE
486	1.7	PNEUMONIA, ORGANISM UNSPECIFIED
518	2.4	OTHER DISEASES OF LUNG

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99233							
ACP		XXX	XXX	1.18	1.25	1.06	1.19
ASIM		XXX	XXX	1.18	1.25	1.06	1.19

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99233								
ACP	1.27	1.25	1.01	1.07	0.98	1.00	INCR	297
ASIM	1.27	1.25	1.01	1.07	0.98	1.00	1.97	321

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99233								
ACP	XXX	1.18	.	.	.	35	.	5
ASIM	XXX	1.18	.	.	.	35	.	5

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99233									
ACP
ASIM

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
99396	Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient; 40-64 years	1.53
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.	1.81

*indicates presence on MPC

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

As compared to 99396, pre-, intra-, and post-service time is similar for 99243. Technical skill is similar for both services; while mental effort is slightly greater for 99396 while psychological stress is slightly greater for 99243. Thus, the RVW for 99243 should be similar to that of 99396. As compared to 12002, pre-, intra-, and post-service time is higher for 99243. 99243 requires more mental effort than 12002, similar technical skill, but less psychological stress. Thus the RVW should be similar to the RVW for 12002.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The weighted median surveyed RVW is 1.91 and the weighted median surveyed total time is 70 minutes. The RVW and total time were derived by weighting the surveyed median RVWs and total times for AAN, ACC, and ASIM more heavily since their members provide this service to Medicare patients more frequently. Also, since 77% of these services are provided by specialties that did not survey these codes, the specialty societies felt it would be appropriate to resurvey these codes. Pre- and post-service time has increased from the 15 minutes extrapolated by Hsiao to the 36 minutes identified by the survey respondents. An explanation for this may be that Hsiao's extrapolated values did not take into account the extent of post-service work between face-to-face encounters. In addition, over the last 5 to 7 years, there has been an increase in the pre and/or post service work due to: increased documentation requirements; increased case management and telephone calls in between face-to-face encounters; increased coordination of care between all treating physicians; increased work of obtaining and documenting referrals; and fewer follow-up visits for the same problem. Because pre- and post-service work increased, the intra-service intensity was recalculated using this data. The revised intra-service intensity for 99243 is 0.027.

Public Comments

06-Jul-95

Code: 99243

1995 RVUs: 147

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y Global Period: XXX Frequency: 1,900,204 Impact:

Source: 7 Year: 93 Public Comment Letter: 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, ACRb, AGS, ANA, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99243	45.1	9.8	9.1	56.9	8.1	0.3	0.8	11.1

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99243	1597330	1977108	11.3

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99243	0.9	0.3	-0.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99243	cardiovascular disease	6.9
	gastroenterology	7.4
	general surgery	9.4
	internal medicine	8.4
	ophthalmology	12.1
	orthopedic surgery	7.3
	otolaryngology	5.8
	urology	10.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99233									
ACP		.		INCR	1.25	xx	n		0.030
ASIM		.		1.97	1.25	xx	n		0.030

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

Code: 99241 Global Period: XXX Current RVW: 0.54 Recommended RVW: 0.63

CPT Descriptor: Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

CPT Code: 99242 Global Period: XXX Current RVW: 1.11 Recommended RVW: 1.25

CPT Descriptor: Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient(s) and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

CPT Code: 99244 Global Period: XXX Current RVW: 2.23 Recommended RVW: 2.50

CPT Descriptor: Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Source and Summary of Comment to HCFA on this service: ACP and others

Low intra-service intensity of E/M codes as compared to all services studied by Hsiao.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the performance of the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The RVWs for these codes were extrapolated from the surveyed codes within this family of services, 99243 and 99245. In extrapolating, we assumed linear relationships within the family of services. The ratios of pre-service plus post-service time to intra-service time and the calculated intra-service intensities of 99243 and 99245 were used to perform the extrapolation. The intra-service intensities for 99213 and 99215 were calculated using the following formula:

$$RVW / [(pre\text{-}service + post\text{-}service\ time / CPT\ intra\text{-}service\ time) + 1] / CPT\ intra\text{-}service\ time.$$

Because of an inconsistency in the survey instrument for the hospital admit, follow-up, and consult codes, the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the office/outpatient visit and consult codes.

Based on the median of the ratios of pre-service plus post-service time to intra-service time and the calculated intra-service intensities of 99243 and 99245, the ratio of pre-service plus post-service time to intra-service time and intra-service intensity were extrapolated to 99241, 99242, and 99244. Once these numbers were available, the RVW was calculated using the above formula.

Public Comments

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Code: 99241 1995 RVUs: 0.54 Recommended RVUs: Inc Ratio:

Long Descriptor: Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 629,060 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, ANA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACRh, ACS, AGS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99241	43.9	9.7	8.3	56.7	8.8	0.5	0.9	15.9

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99241	698463	669836	-2.1

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99241	1.1	0.5	-0.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99241	dermatology	8.7
	gastroenterology	5.3
	general surgery	19.4
	group practices	4
	internal medicine	4.5
	orthopedic surgery	7.2
	otolaryngology	6.9
	urology	9.5

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Claims-Level Diagnosis Information:**Harvard Data:**

Comm	Modif	Packhrv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99241							
ACP			XXX	0.55	0.54	0.98	0.55

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99241								
ACP	0.55	0.54	1.00	1.00	0.98	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99241								
ACP	XXX	0.55				15		6

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99241									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99241									
ACP				INCR	0.54				0.027

Public Comments

06-Jul-95

Code: 99242

1995 RVUs: 1.11

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient(s) and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 1,159,646 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, ANA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACRH, ACS, AGS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99242	44.8	10.1	8	56.1	8.5	0.4	0.9	14.5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99242	1079737	1217532	6.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99242	1	0.4	-0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99242	dermatology	7.8
	gastroenterology	5.6
	general surgery	15
	internal medicine	5.8
	ophthalmology	6.3
	orthopedic surgery	8.5
	otolaryngology	8.9
	urology	12.1

Public Comments

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Claims-Level Diagnosis Information:**Harvard Data:**

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99242							
ACP		XXX	XXX	1.12	1.11	0.99	1.12

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99242								
ACP	1.13	1.11	1.00	1.01	0.98	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
99242								
ACP	XXX	1.12				30		12

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99242									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99242									
ACP				INCR	1.11	xx	n		0.027

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

Number: 99243 Global Period: XXX Current RVW: 1.47 Recommended RVW: 1.91

E/M Descriptor: Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Source and Summary of Comment to HCFA on this service: ACP and others

Low intra-service intensity of E/M codes as compared to all services studied by Hsiao.

CLINICAL DESCRIPTION OF SERVICE:

Vignettes Used in Survey:

AAFP/AOA: Outpatient consultation for a 55 year old female with positive mammography sent for a pre-operative evaluation by a surgeon. Detailed history including any changes in self breast exams, gynecological system, weight changes, and prior complications with anesthesia. Detailed exam including breast exam and gynecological system. Medical decision making of low complexity including discussion with the patient about the procedure and possible outcomes and necessity for follow-up.

AAN: A 29 year-old male meat cutter referred for an office consultation for progressive symptoms of paresthesias in the right hand awakening him from sleep and while driving. Examination is normal except for mild thenar wasting and weakness on the right and subjective median sensory loss.

A: Office consultation for a 10 year old with chronic cough treated with repetitive courses of antibiotics. Detailed history including respiratory history, fever, labored breathing, characteristics of pain, allergies, and appetite. A detailed examination including ear, nose, and throat, respiratory, and immunologic. Medical decision making of low complexity and a discussion of asthma and treatment plans are initiated with the family.

ACC: Office consultation for a 31 year-old woman complaining of palpitations and chest pains. Her internist described a mid-systolic click. The physician performs a detailed history, encouraging patient to describe her pain and palpitations as it relates to stress and any recent-life changes. A detailed physical examination is conducted including cardiac examination standing and lying-down. Medical decision making is of low complexity and includes explanation of symptoms as a function of autonomic nervous system reactivity, and life style modification to alleviate symptoms.

ACRn: Initial office consultation for a 45 year old female with diabetes mellitus, hypertension, diffuse psoriasis, and arthritis unresponsive to anti-inflammatory medications.

AOA/ASIM: 74 year old female with previously known cirrhosis who has recently developed moderate ascites without other complication.

Description of Pre-Service Work: Preparing to see the patient, reviewing records, and communicating with other professionals as appropriate.

Description of Intra-Service Work: A detailed history, a detailed examination, and medical decision making of low complexity.

Description of Post-Service Work: All coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding care plan oversight of more than 30 minutes per month for home health and hospice patients).

KEY DATA:

Filter: AAFP, AAN, AAP, ACC, ACRh, AOA, ASIM

Sample Size: 878 Response Rate (%): 15% Weighted Median Surveyed RVW: 1.91

Percentile RVW: 1.38 75th Percentile RVW: 1.90 Low: 0.40 High: 4.09

Median Pre-Service Time: 5 min Median Intra-Service Time: 30 min

Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 40 Low: 5 High: 60

Median Total Post-Service Time: 31 min

Median Post Service Times For:

Documentation of service provided: 10 min

Arranging for further services: 5 min

Reviewing results of studies: 5 min

Communicating further with patient, family,
and other professionals including reports: 10 min

Providing written or telephone reports to
Medicare or other third party payors: 5 min

Providing care plan oversight services
(less than 30 minutes per month): NA

Has the work of performing this service changed in the past 5 years?

Yes 59% No 41%

The typical complexity of the patient problems being seen in the office has:

Increased 72% Decreased 0% Stayed the Same 28%

The physician work associated with coordination of oversight of care provided by other health professionals has:

Increased 83% Decreased 0% Stayed the Same 17%

The physician work required to document the services provided has:

Increased 84% Decreased 0% Stayed the Same 16%

Do you agree that the Typical Service/Patient provided above describes your typical patient?

Yes 87% No 13%

Public Comments

06-Jul-95

Code: 99243

1995 RVUs: 1.47

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 1,900,204 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, ACRh, AGS, ANA, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99243	45.1	9.8	9.1	56.9	8.1	0.3	0.8	11.1

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99243	1597330	1977108	11.3

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99243	0.9	0.3	-0.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99243	cardiovascular disease	6.9
	gastroenterology	7.4
	general surgery	9.4
	internal medicine	8.4
	ophthalmology	12.1
	orthopedic surgery	7.3
	otolaryngology	5.8
	urology	10.5

Public Comments

06-Jul-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99243			
	362	1.4	OTHER RETINAL DISORDERS
	366	1.7	CATARACT

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99243							
ACP		XXX	XXX	1.47	1.47	1.00	1.48

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99243								
ACP	1.49	1.47	1.01	1.01	0.99	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
99243								
ACP	XXX	1.47				40		15

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99243									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99243									
ACP				INCR	1.47	xx	n		0.027

Public Comments

06-Jul-95

Code: 99244

1995 RVUs: 2.23

Recommended RVUs: Inc

Ratio:

Long Descriptor: Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 2,339,609 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, ANA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACRh, ACS, AGS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99244	45.3	9.6	9.6	56.6	8.3	0.3	0.9	8.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99244	2212372	2451922	5.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99244	1.2	0.4	-0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99244	cardiovascular disease	9.9
	gastroenterology	7.3
	general surgery	5
	hematology/oncology	6
	internal medicine	9.6
	neurology	13
	ophthalmology	11.4

Public Comments

06-Jul-95

urology	4.6
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Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
99244		
362	1.7	OTHER RETINAL DISORDERS
366	1.2	CATARACT
401	1.1	ESSENTIAL HYPERTENSION
786	1.3	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhvr	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99244							
ACP		XXX	XXX	2.18	2.23	1.02	2.18

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
99244								
ACP	2.25	2.23	1.00	1.03	0.99	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
99244								
ACP	XXX	2.18				60		22

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
99244									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99244									
ACP				INCR	2.23	xx	n		0.027

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

File: 99245 Global Period: XXX Current RVW: 2.96 Recommended RVW: 3.21

PT Descriptor: Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

Source and Summary of Comment to HCFA on this service: ACP and others

Low intra-service intensity of E/M codes as compared to all services studied by Hsiao.

CLINICAL DESCRIPTION OF SERVICE:

Cigarettes Used in Survey:

AFP/AOA: Outpatient consultation for 74 year old male with a history of coronary artery disease and diabetes undergoing a pre-operative evaluation for elective hip replacement. Comprehensive history including cardiopulmonary system, blood sugar control, medications, prior complication with anesthesia. Comprehensive exam including heart, lungs, extremities and skin. Medical decision making of high complexity including recommendations for pre-op lab and medications and possible post-op complications, discussion with the patient about nutrition and blood sugar control and importance of compliance and follow-up.

AN: A 50 year-old female is referred for an office consultation for 3 month history of weakness and atrophy of the right arm and gait deterioration. Examination shows loss of reflexes atrophy and weakness in the right arm and a spastic paraparesis with bilateral upper extremity and trunk muscle atrophy.

AN: Office consultation for 16 year old referred for evaluation of drug use. Comprehensive history including school performance, sexual activity, alcohol and substance abuse, peer and family relationships. Comprehensive examination including psychological and neurological examinations. Medical decision making of high complexity and detailed discussion with the patient and her parents is undertaken with appropriate referral for laboratory studies, medical and psychological care.

APM: Initial office consultation for a 36 year old male, one year status post occupational herniated cervical disk treated by laminectomy, requiring management of multiple sites of intractable pain, depression, and narcotic dependence. Physician performs a comprehensive history and a comprehensive physical and neurological examination. Medical decision making is of high complexity due to operative intervention, depression, and narcotic dependence. Imaging, electrodiagnostic, and psychometric tests are ordered, and a diagnosis formulated. A coordinated treatment plan with pharmacologic/interventions, behavioral pain management strategies and physical therapy/rehabilitation is instituted.

CC: Office consultation for a 58 year-old man with history of MI and CHF who complains of the recent onset of rest angina and shortness of breath. The patient has a systolic blood pressure of 90mmHG and is in Class IV heart failure. The physician performs a comprehensive history including review of salt intake, appropriateness of and compliance with medications. A comprehensive physical examination is conducted including heart, lungs, abdomen, legs, vascular system in neck and extremities. Alternative approaches to diagnosis and therapy are discussed with the patient. Medical decision making is of high complexity and involves consideration of hospitalization, therapy for angina and dyspnea, lab work to confirm or deny new myocardial infarction, and possible diagnostic procedures including echocardiography and/or cardiac catheterization.

CRh: Office consultation for 6 year old male for evaluation of severe muscle and joint pain and a diffuse rash. Well until 4 - 6 weeks earlier when he developed arthralgia, myalgias, and a fever of 102 for 1 week.

OA/ASIM: Outpatient consultation for 74 year old male with a history of coronary artery disease and diabetes undergoing a pre-operative evaluation for elective hip replacement.

Description of Pre-Service Work: Preparing to see the patient, reviewing records, and communicating with other professionals as appropriate.

Description of Intra-Service Work: A comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Description of Post-Service Work: All coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding care plan oversight of more than 30 minutes per month for home health and hospice patients).

SURVEY DATA:

Specialty: AAFP, AAN, AAP, AAPM, ACC, ACRh, AOA, ASIM

Sample Size: 932 Response Rate (%): 17% Weighted Median Surveyed RVW: 2.50

25th Percentile RVW: 2.00 75th Percentile RVW: 3.06 Low: 0.50 High: 8.00

Median Pre-Service Time: 10 min Median Intra-Service Time: 47.5 min

25th Percentile Intra-Svc Time: 35 75th Percentile Intra-Svc Time: 65 Low: 11 High: 110

Median Total Post-Service Time: 50 min

Median Post Service Times For:

Documentation of service provided: 10 min

Arranging for further services: 10 min

Reviewing results of studies: 10 min

Communicating further with patient, family, and other professionals including reports: 15 min

Providing written or telephone reports to Medicare or other third party payors: 10 min

Providing care plan oversight services less than 30 minutes per month): NA

Has the work of performing this service changed in the past 5 years?

Yes 72% No 28%

The typical complexity of the patient problems being seen in the office has:

Increased 81% Decreased 0% Stayed the Same 19%

The physician work associated with coordination of oversight of care provided by other health professionals has:

Increased 89% Decreased 0% Stayed the Same 11%

The physician work required to document the services provided has:

Increased 91% Decreased 0% Stayed the Same 9%

Do you agree that the Typical Service/Patient provided above describes your typical patient?

Yes 88% No 12%

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity.	2.41
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	1.81

*indicates presence on MPC

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

As compared to 99220, pre-, intra-, and post-service time are higher for 99245. Mental effort and technical skill are similar, while psychological stress is higher for 99245. The RVW for 99245 should be higher than the RVW for 99220. As compared to 12002, 99245 requires more mental effort, technical skill, and time than 12002, but less psychological stress. Thus the RVW for 99245 should be significantly greater than the RVW for 12002.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The weighted median surveyed RVW is 3.21 and the median total time is 107.5 minutes. The RVW and total time were derived by weighting the surveyed median RVWs and total times for AAN, ACC, and ASIM more heavily since their members provide this service to Medicare patients more frequently. Also, since 59% of these services are provided by specialties that did not survey these codes, the specialty societies felt it would be appropriate to resurvey these codes. Pre- and post-service time has increased from the 29 minutes extrapolated by Hsiao to the 60 minutes identified by the survey respondents. An explanation for this may be that Hsiao's extrapolated values did not take into account the extent of post-service work between face-to-face encounters. In addition, over the last 5 to 7 years, there has been an increase in the pre and/or post service work due to: increased documentation requirements; increased case management and telephone calls in between face-to-face encounters; increased coordination of care between all treating physicians; increased work of obtaining and documenting referrals; and fewer follow-up visits for the same problem. Because pre-service work increased, the intra-service intensity was recalculated using this data. The revised intra-service intensity for 99245 is 0.0279.

Public Comments

06-Jul-95

Code: 99245 1995 RVUs: 2.96 Recommended RVUs: Inc Ratio:

Long Descriptor: Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 1,113,744 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, ACRh, AGS, ANA, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACEP, ACOG, ACS, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99245	45.4	9.3	10.1	56.6	8.9	0.5	0.9	6.1

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99245	951227	1163029	10.6

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99245	1.3	0.4	-0.4

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99245	cardiovascular disease	10.8
	gastroenterology	4.9
	general surgery	4.1
	hematology/oncology	10.5
	internal medicine	12.9
	neurology	13.4
	ophthalmology	6.2
	pulmonary disease	4.2

Public Comments

06-Jul-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99245	250	1	DIABETES MELLITUS
	401	1.4	ESSENTIAL HYPERTENSION
	414	1.2	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
	780	1	GENERAL SYMPTOMS
	786	1.4	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99245	ACP		XXX	XXX	2.88	2.96	1.03	2.87

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99245	ACP	2.98	2.96	1.00	1.04	0.99	1.00	INCR	297

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99245	ACP	XXX	2.88				80		29

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuis	Offvis
99245	ACP									

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99245	ACP				INCR	2.96	xx	n		0.027

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 99251 Global Period: XXX Current RVW: 0.54 Workgroup Recommended RVW: 0.54

CPT Descriptor: Initial inpatient consultation for a new or established patient, which requires these three key components:

1. a problem focused history;
2. a problem focused examination; and
3. Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has also increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

CPT Code: 99252 Global Period: XXX Current RVW: 1.13 Workgroup Recommended RVW: 1.13

CPT Descriptor: Initial inpatient consultation for a new or established patient, which requires these three key components:

1. an expanded problem focused history;
2. an expanded problem focused examination; and
3. straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

CPT Code: 99254 Global Period: XXX Current RVW: 2.27 Workgroup Recommended RVW: 2.27

CPT Descriptor: Initial inpatient consultation for a new or established patient, which requires these three key components:

1. a comprehensive history;
2. a comprehensive examination; and
3. medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has also increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

These services were not surveyed directly for the five year review. Our recommendations for these services are based upon the intra-service intensity that was found for the other two codes in this family of service (99253 and 99255).

Based on the survey results, consensus recommendations and intra-service intensities, for other services within this family of codes that were directly surveyed, the organizations surveying evaluation and management codes recommend that the RVW for 99251 be increased to 0.63, the RVW for 99252 be increased to 1.25, and the RVW for 99254 be increased to 2.5.

Post-service time has increased substantially in recent years because of the increase in documentation; more time spent tracking down information while the patient is in the hospital; more time spent discussing treatment options with the patient, family, and the primary care physician; because physicians are working with frailer patients than five years ago and because of the compression of the hospital stay.

Because of the inconsistency in the survey instrument (see "rationale" of CPT Code 99223), the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the hospital visit and consult codes.

Specialty: Calculated data: American Society of Internal Medicine, American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association, American College of Cardiology, American College of Rheumatology, American Academy of Neurology, American Academy of Pain Medicine, American Geriatrics Society, American Nurses Association, and American Academy of Physician Assistants

Public Comments

06-Jul-95

Code: 99251

1995 RVUs: 0.54

Recommended RVUs: Inc

Ratio:

Long Descriptor: Initial inpatient consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 514,814 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACOG, ACRh, ACS, AGS, ANA, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99251	55.2	19	13.5	56.4	11.4	1	2.8	13.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99251	721227	591573	-9.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99251	90	88.4	-0.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99251	anesthesiology	5.3
	gastroenterology	4.9
	general surgery	16.4
	general/family practice	4.4
	internal medicine	8.3
	orthopedic surgery	5.3
	podiatry	10.9

Public Comments

06-Jul-95

urology	8.3
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Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99251	110	1.3	DERMATOPHYTOSIS
	250	1.2	DIABETES MELLITUS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99251							
ACP			XXX		0.54		0.56

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
99251								
ACP	0.57	0.54		1.02	0.95	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
99251								
ACP	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	alcuvis	Offvis
99251									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99251									
ACP				INCR	0.54				

Public Comments

06-Jul-95

Code: 99252 1995 RVUs: 1.13 Recommended RVUs: Inc Ratio:

Long Descriptor: Initial inpatient consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination, and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n): Y Global Period: XXX Frequency: 936,954 Impact:

Source: 7 Year: 93 Public Comment Letter: 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACOG, ACRh, ACS, AGS, ANA, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99252	56.1	18.8	13.6	55	10.2	0.9	2.9	13.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99252	1144223	1068167	-3.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99252	94.4	94.3	-0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99252	cardiovascular disease	7.7
	gastroenterology	6.9
	general surgery	14.8
	general/family practice	3.9
	internal medicine	11.5
	orthopedic surgery	6.4
	podiatry	3.7

Public Comments

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urology	9.1
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Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99252	250	1.1	DIABETES MELLITUS
	414	1.2	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
	427	1	CARDIAC DYSRHYTHMIAS
	789	1.1	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99252							
ACP		XXX	XXX	1.12	1.13	1.01	1.13

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99252								
ACP	1.15	1.13	1.01	1.02	0.98	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99252								
ACP	XXX	1.12				32		8

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99252									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99252									
ACP				INCR	1.13	xx	n		0.030

Public Comments

06-Jul-95

Code: 99254 **1995 RVUs:** 2.27 **Recommended RVUs:** Inc **Ratio:**

Long Descriptor: Initial inpatient consultation for a new or established patient, which requires three key components: a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 3,224,176 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297.

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACOG, ACRh, ACS, AGS, ANA, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA, RPA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99254	55.8	17.8	14	55.4	9	0.8	2.6	7.3

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99254	3464824	3617997	2.2

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99254	97.4	97.1	-0.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99254	cardiovascular disease	16.5
	gastroenterology	8.7
	general surgery	5.7
	hematology/oncology	3.5
	infectious disease	3.7
	internal medicine	14.6
	neurology	11.7

Public Comments

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pulmonary disease	8.5
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Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
99254		
401	1.2	ESSENTIAL HYPERTENSION
414	1.6	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	1.7	CARDIAC DYSRHYTHMIAS
428	1.5	HEART FAILURE
780	1.4	GENERAL SYMPTOMS
786	1.3	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99254							
ACP		XXX	XXX	2.18	2.27	1.04	2.19

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99254								
ACP	2.29	2.27	1.00	1.05	0.99	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99254								
ACP	XXX	2.18				65		15

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99254									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99254									
ACP				INCR	2.27	xx	n		0.030

Description of Post-Service Work:

CPT Code 99253

Post-service work includes all coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals, associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding care plan oversight of more than 30 minutes per month for home health and hospice patients). (ALL)

SURVEY DATA:

Specialty: Combined data: American Society of Internal Medicine, American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association, American College of Cardiology, American College of Rheumatology, and American Academy of Neurology

Sample Size: 155/902 Response Rate (%): 17% Weighted Median RVW: 1.9

25th Percentile RVW: 1.4 75th Percentile RVW: 2.1 Low: 0.47 High: 4.0

Median Pre-Service Time: 10 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 20 minutes 75th Percentile Intra-Svc Time: 40 minutes

Low Intra-Svc Time: 10 minutes High Intra-Svc Time: 60 minutes

Median Post-Service Time: 35 minutes

Elements of Post Time:

Median time for documentation of the service provided: 10 minutes

Median time for arranging for further services: 5 minutes

Median time for reviewing results of studies: 5 minutes

Median time for communicating further with patient, family, and other professionals including reports: 10 minutes

Median time for providing written or telephone reports to Medicare or other third party payers: 5 minutes

Median time for providing care plan oversight services less than 30 minutes per month: X minutes

* Care plan oversight was not included on most survey reporting forms.

Work Changed?: Complexity: Increased: 75.8% Decreased: 3.2% Same: 21%

Oversight: Increased: 82.5% Decreased: 2.1% Same: 15.4%

Documentation: Increased: 88.2% Decreased: 0% Same: 11.8%

Vignette Typical: Yes: 88.4% No: 11.6%

Demographics (who responded):

General internists: 25 Family physicians: 47 Pediatricians: 26

Urologists: 26 Internal Medicine Subspecialists: 31

Breakdown by Subspecialty: Cardiology 9, Rheumatology 10, Endocrinology 2, Pulmonology 2, Allergy 2, Gastroenterology 2, Nephrology 3, Infectious Disease 1.

KEY REFERENCE SERVICE(S):

CPT Code 99253

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99219	Observation Care	1.75
2)	99218	Observation Care	1.08
3)	45235	Upper GI Endoscopy, Diagnostic	2.39

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The elements of work (mental effort, technical skill and psychological stress) and pre and intra time were measured by the survey instrument to be similar to 45235, but the post-service time was measured to be slightly higher than 43235. Interestingly, the RVW for the reference service is much higher (2.39) than the current RVW for 99253.

The respondents also rated the service to be similar to 99219. The survey respondents rated the mental effort higher for 99253 than 99219 and judged the technical skill and stress to be similar. The respondents also rated the pre and intra times for 99253 and 99219 to be the same, but the post times for 99253 to be slightly higher. Compared to 99218, mental effort, technical skill and psychological stress were all rated higher for 99253, pre and intra time were rated as being similar and post-service time was rated higher for 99253. This is because a mid-level consultation typically requires more data to review and process than for a mid-level observation patient. These days, the consultant doesn't just dispense advice, but typically initiates management of the problem on hand.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The surveying organizations recommend that the RVW be increased to 1.9. The combined median RVW for this service was 1.8, however weighted median RVWs for the groups that provide this service the most often (internists and cardiologists) is 1.9. According to 1994 Medicare Part B data, internists and cardiologists account for 27.7% of all billings for this service. These two specialties bill this service more than any other specialty. The next highest specialty, that surveyed this code, was neurology at 4.4%.

The total time estimates for this service are much higher than the current assumption of 55 minutes (the median total time is 75 minutes). The median total time for internists and cardiologists is 83 minutes (which was the figure used in the intra-service intensity calculation). The median combined pre/post time estimate is 4.5 times higher than the current assumption of 10 minutes. Post-service time has increased substantially in recent years because of the increase in documentation; more time spent tracking down information while the patient is in the hospital; more time spent discussing treatment options with the patient, family, and the primary care physician; and because of the compression of the hospital stay. The intra-service time estimates were lower than the current assumption of 45 minutes, but some of the post-service time could be attributed to the intra-service time, per the discussion on 99223.

In regard to the clinical example and vignette used by ASIM, ACP, AAFP, and AOA, five years ago the consultant would be treating a patient with a lower fever threshold than today. Today, consultants are typically called in only when standard tests and antibiotics haven't resolved the problem or point to potentially serious complications, such as antibiotic resistance, occult deep infection, or fungal sepsis. The typical hospital patient having surgery is more complex than five years ago because the less complex patients are being treated on an outpatient basis.

CPT Code 99253

Because of the inconsistency in the survey instrument (see "rationale" of CPT Code 99223), the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the hospital visit and consult codes.

Public Comments

Code: 99253

1995 RVUs: 1.56

Recommended RVUs: Inc

Ratio:

Long Descriptor:

Initial inpatient consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n):

Y

Global Period: XXX

Frequency: 1,945,305

Impact:

Source: 7

Year: 93

Public Comment Letter: 297

Reference Services:

CMD Comment:

Societies Wishing to Survey:

AAFP, AAN, AAP, AAPM, ACP, ACR, AGS, AOA, ASIM

Societies Wishing to Comment:

AACAP, AAO-HNS, AAPMR, ACCP, ACOG, ACS, ANA, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99253	55.6	18.1	13.4	56	9.4	0.8	2.9	10.5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99253	2070064	2185182	2.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99253	95.8	95.6	-0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99253	cardiovascular disease	13.2
	gastroenterology	9.2
	general surgery	10.1
	internal medicine	14.5
	neurology	4.4
	pulmonary disease	4.9
	rehabilitation medicine	4.3
	urology	5.9

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Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
99253		
250	1.1	DIABETES MELLITUS
401	1.2	ESSENTIAL HYPERTENSION
414	1.4	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	1.4	CARDIAC DYSRHYTHMIAS
428	1.2	HEART FAILURE
786	1.2	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS
789	1.1	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99253							
ACP		XXX	XXX	1.47	1.56	1.06	1.49

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99253								
ACP	1.58	1.56	1.01	1.06	0.99	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
99253								
ACP	XXX	1.47				45		10

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdviedur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99253									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99253									
ACP				INCR	1.56	xx	n		0.030

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 99253 Global Period: XXX Current RVW: 1.56 Recommended RVW: 1.9

CPT Descriptor: Initial inpatient consultation for a new or established patient, which requires these three key components:

1. a detailed history;
2. a detailed examination; and
3. medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has also increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Initial inpatient consultation for diagnosis/management of fever following abdominal surgery. (ASIM/ACP/AAFP/AOA)

Initial hospital consultation for a 8 year old female, 48 hours post appendectomy, who develops a fever of 104 degrees with abdominal pain and vomiting. (AAP/AOA)

Initial inpatient preoperative consultation for a 58 year old woman with cholecystitis and poorly controlled hypertension. (ACC)

Initial hospital consultation for a 50 year old female with incapacitating knee pain due to generalized rheumatoid arthritis. (ACR)

Initial hospital consultation for a 39 year old male with left hand weakness and paresthesia of the fourth and fifth fingers following left inguinal hernia surgery four days ago, but now improving. Examination reveals mild weakness of ulnar innervated muscles and patchy sensory loss over fifth and medial fourth finger, without other weakness or reflex changes. (AAN)

Description of Pre-Service Work:

Pre-service work includes preparing to see the patient, reviewing records, and communicating with other professionals, as appropriate. (ALL)

Description of Intra-Service Work:

Detailed history including infection sources and risk factors. Detailed exam including rectal (and bimanual pelvic in female). Medical decision making of low complexity including review of lab, scan results with discussion with surgeon, radiologist. Counseling regarding diagnosis and treatment plans. (ASIM/ACP/AAFP/AOA)

Examination reveals a right lower lobe pneumonia. Appropriate confirmatory laboratory and x-rays studies and intravenous antibiotics are ordered and reviewed. No evidence of peritonitis or wound infection is found. (AAP/AOA)

The physician performs a detailed history and detailed physical examination including confirmation of blood pressure, appropriateness and compliance with home medication, physical examination of abdomen. Medical decision making of low complexity and involves ordering lab work to check liver and kidney function, and electrolyte balance, abdominal ultrasound, decision regarding antibiotics and possible postponement of surgery. (ACC)

The history, x-rays, and an MRI are reviewed. A detailed examination of the extremities is undertaken, with particular attention to the knees. Therapy is recommended. (ACR)

Includes a detailed history, detailed examination, and medical decisionmaking of low complexity. (AAN)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 99255 Global Period: XXX Current RVW: 3.14 Recommended RVW: 3.4

CPT Descriptor: Initial inpatient consultation for a new or established patient, which requires these three key components:

1. a comprehensive history;
2. a comprehensive examination; and
3. medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has also increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Initial hospital consultation for a 66 year-old female, two days post-abdominal aneurysm repair, with oliguria and hypertension of one day duration. (ASIM/ACP/AAFP/AOA)

Initial inpatient consultation for a 16 year old female hospitalized with abdominal pain and vomiting, who is found to be pregnant. (AAP/AOA)

Initial hospital consultation for a 50 year old man with a history of previous myocardial infarction, who now presents with acute pulmonary edema and hypotension. (ACC)

Initial inpatient consultation for a 36 year old male admitted with hemoptysis whose radiographic studies show widespread interstitial pulmonary changes. (ACR)

Initial hospital consultation for a 62 year old male having suffered an in-hospital cardiac arrest. Following examination findings including absent brainstem activity and a negative apnea test, the family members present request explanation of findings. (AAN)

Initial hospital consultation for a 45 year old female with widely metastatic lung carcinoma, intractable back pain, and a history that includes substance dependence, NSAID allergy, and two prior laminectomies with fusion for low back pain. (AAPM)

Description of Pre-Service Work:

Pre-service work includes preparing to see the patient, reviewing records, and communicating with other professionals, as appropriate. (ALL)

Description of Intra-Service Work:

Comprehensive history, including review of actual location and complexity of surgical repair, review of all events since admission, urinary and renal systems, cardiovascular system, review of all lab tests and all input/output. Comprehensive exam, including cardiovascular system, urinary/renal system, abdomen and incisional area. Medical decision making of high complexity, including discussion of necessary diagnostic tests/procedures with patient, family, and current care team. (ASIM/ACP/AAFP)

Comprehensive examination reveals signs of resolving dehydration as well as evidence of substance abuse. Appropriate confirmatory laboratory studies are ordered and reviewed. Discussion with patient and family regarding the implications of her pregnancy are undertaken. Obstetrical and psychiatric referrals are made. (AAP)

The physician performs a comprehensive history and comprehensive physical examination including heart, lungs, extremities and confirmation of blood pressure. Alternative approaches to diagnosis and therapy, as well as prognosis are discussed with the patient. Medical decision making is of high complexity and involves ordering lab work to assess renal function and to confirm or rule out recurrent myocardial infarction, considering of Swan-Ganz catheterization or use of intra-aortic balloon pump, initiation of appropriate medical therapy to increase blood pressure and relieve pulmonary edema and planning for follow up treatment for heart and blood pressure based on initial findings. (ACC)

Further history is elicited from family members. A comprehensive exam of the heart, lungs, abdomen, joints, and integument is performed. A wide range of laboratory studies are ordered and emergency imaging studies are arranged. Presumptive disease modifying treatment is initiated. (ACR)

Includes a comprehensive history, comprehensive examination, and medical decisionmaking of high complexity. (AAN)

CPT Code 99255

Physician performs a comprehensive history and a comprehensive physical and neurological examination to assess the etiology of the intractable back pain and metastatic spread of disease. Medical decision making is of high complexity due to the prior operative interventions, metastatic spread of disease, substance dependence and psychosocial impact of malignant disease. Imaging electrodiagnostic and psychometric tests are ordered. A diagnosis is formulated and a coordinated treatment plan with somatic/pharmacologic/radiation diagnostic interventions, behavioral counseling and pain management strategies, and physician therapy/rehabilitation is instituted. Treatment planning and counseling of a patient with pain of malignant origin requires a longer duration of time and higher intensity due to the severe psychosocial impact of malignant disease. (AAPM)

Description of Post-Service Work:

Post-service work includes all coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals, associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding care plan oversight of more than 30 minutes per month for home health and hospice patients). (ALL)

SURVEY DATA:

Specialty: Combined data: American Society of Internal Medicine, American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association, American College of Cardiology, American College of Rheumatology, American Academy of Neurology, and American Academy of Pain Medicine

Sample Size: 182/955 Response Rate (%): 19% Weighted Median RVW: 3.4

25th Percentile RVW: 2.41 75th Percentile RVW: 3.6 Low: 0.5 High: 8.0

Median Pre-Service Time: 15 minutes Median Intra-Service Time: 45 minutes

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 70 minutes

Low Intra-Svc Time: 10 minutes High Intra-Svc Time: 120 minutes

Median Post-Service Time: 57 minutes

Elements of Post Time:

Median time for documentation of the service provided: 15 minutes

Median time for arranging for further services: 15 minutes

Median time for reviewing results of studies: 10 minutes

Median time for communicating further with patient, family, and other professionals including reports: 15 minutes

Median time for providing written or telephone reports to Medicare or other third party payers: 10 minutes

Median time for providing care plan oversight services less than 30 minutes per month: X minutes*

* Care plan oversight was not included on most survey reporting forms.

Work Changed?: Complexity: Increased: 84.8% Decreased: 2.7% Same: 12.5%

Oversight: Increased: 87.4% Decreased: 0% Same: 12.6%

Documentation: Increased: 90.8% Decreased: 0% Same: 9.2%

Vignette Typical?: Yes: 80.7% No: 19.3%

CPT Code 99255

Demographics (who responded): General internists: 21 Family physicians: 47
 Pediatricians: 37 Pain management: 15 Neurologists: 26 Internal Medicine Subspecialists: 36
 Breakdown by Subspecialty: Cardiology 9, Rheumatology 15, Endocrinology 2, Pulmonology 2, Allergy 2,
 Gastroenterology 2, Nephrology 3, Infectious Disease 1.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99220	Observation Care	2.41
2)	45378	Diagnostic Colonoscopy	3.7

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

99255 was rated by survey respondents as higher across the board than 99220 (mental effort, technical skill, psychological stress, pre time, intra time, and post time). This is because level five hospital consult patients are typically more ill than observation unit patients, the hospital patients often have multisystem problems requiring complex treatments, more testing options and greater risk of deterioration. Pre time is very much more involved for the level five hospital consult patient because the chart and previous tests must be reviewed and the consultant often must discuss the patient with the referring physician. Similarly, post time is also more involved due to development of the care plan and coordination of care with the referring physician and/or other providers, such as physical therapists.

Similarly, 99255 was rated higher than 45378 in each category, except for technical skill. Technical skill is higher for endoscopy. However, mental effort of the thought process and the psychological stress are greater because of the potential complications if the treatment plan is incorrect or inadequate. Intra-service time is longer for the consult—the endoscopy shouldn't take more than 30 minutes whereas the consultant spends almost two hours (CPT typical time 110 minutes) on the patients hospital unit. Pre time are very much more involved for the level five hospital consult patient because the chart and previous tests must be reviewed and the consultant often must discuss the patient with the referring physician. Similarly, post time is also more involved due to development of the care plan and coordination of care with the referring physician and/or other providers, such as physical therapists.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The organizations surveying evaluation and management codes recommend that the RVW be increased to 3.4. Although the combined median RVW is 3.0, the median RVW is higher among the specialties that bill this service more frequently (3.4 to 3.64). The weighted median recommendation of 3.4 is supported by 1994 Medicare Part B billing data that indicates that cardiologists, internists, and neurologists account for 45.3% of all billings for this service. These three specialties bill this service more frequently than any other specialty. All the other specialties that surveyed this code account for less than 4% of billings for this service.

CPT Code 99255

The combined median total time estimate of 117 minutes for this service is slightly higher than the current assumption of 110 minutes. Again, the median total times for the specialties that bill this service most often were much higher (145 minutes) – the later time estimate was used in determining intra-service intensity. The combined pre/post time estimate of 72 minutes is 3.3 times higher than the current assumption of 22 minutes. Post-service time has increased substantially in recent years because of the increase in documentation; more time spent tracking down information while the patient is in the hospital; more time spent discussing treatment options with the patient, family, and the primary care physician; because physicians are working with frailer patients than five years ago and because of the compression of the hospital stay. The intra-service time estimate was much lower than the current assumption, but some of the post-service time could be attributed to the intra-service time, per the discussion regarding the recommendation for 99223.

Less ill patients are likely to be treated on the outpatient basis, meaning that the complexity of patients has increased, particularly for the more complex levels of patients, as data gathered from the HCFA *Health Care Financing Review* indicates. Hospital length of stay has decreased 10.1 percent for Medicare beneficiaries during the five year period of 1988 to 1993 (from 8.9 to 8.0). The hospital discharge rate has decreased 1.6 percent during the same period (from 316 per 1000 enrollees to 311). This means that more data has to be gathered, more difficult judgements made, and more risk is involved with the decision making when the consultation is made on the typical level five consultation patient who will be in the hospital for a shorter period of time than he/she would have five years ago.

Because of the inconsistency in the survey instrument (see "rationale" of CPT Code 99223), the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the hospital visit and consult codes.

Public Comments

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Code: 99255 1995 RVUs: 3.14 Recommended RVUs: Inc Ratio:

Long Descriptor: Initial inpatient consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n): Y Global Period: XXX Frequency: 1,744,879 Impact:

Source: 7 Year: 93 Public Comment Letter: 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, ACR, AGS, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACOG, ACS, ANA, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA, RPA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99255	54.4	16.6	14	54.3	9.2	0.8	2.6	6.5

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99255	1645149	1946805	8.8

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99255	98	97.9	-0.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99255	cardiovascular disease	18.6
	gastroenterology	5.7
	general surgery	4.1
	hematology/oncology	5.1
	infectious disease	4.6
	internal medicine	16.2
	neurology	10.5

Public Comments

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pulmonary disease	9.8
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Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99255	250	1	DIABETES MELLITUS
	401	1.2	ESSENTIAL HYPERTENSION
	414	1.9	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
	427	1.9	CARDIAC DYSRHYTHMIAS
	428	1.8	HEART FAILURE
	518	1.5	OTHER DISEASES OF LUNG
	780	1.5	GENERAL SYMPTOMS
	786	1.4	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99255	ACP		XXX	XXX	2.88	3.14	1.09	2.88

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99255	ACP	3.16	3.14	1.00	1.10	0.99	1.00	INCR	297

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99255	ACP	XXX	2.88				88		22

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	lcuvis	Offvis
99255	ACP									

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99255										

Public Comments

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ACP	.	INCR	3.14	xx	n	0.030
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**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 99261 Global Period: XXX Current RVW: 0.36 Recommended RVW: 0.65

CPT Descriptor: Follow-up inpatient consultation for an established patient which requires at least two of these three key components:

1. a problem focused interval history;
2. a problem focused examination; and
3. medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has also increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

CPT Code: 99263 Global Period: XXX Current RVW: 1.16 Recommended RVW: 1.95

CPT Descriptor: Follow-up inpatient consultation for an established patient which requires at least two of these three key components:

1. a detailed interval history;
2. a detailed examination; and
3. medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and risk. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

(14)

CPT Codes 99261 and 99263

These services were not surveyed directly for the five year review. Our recommendations for these services are based upon the intra-service intensity that was found for the other code in this family of service (99262).

Based on the survey responses, consensus recommendations and intra-service intensity for the surveyed codes, the organizations surveying evaluation and management (E/M) codes recommend that the RVW for 99261 be increased to 0.65 and the RVW for 99263 be increased to 1.95. These RVW recommendations fall in-line with the recommendation for 99262.

Because of the inconsistency in the survey instrument (see "rationale" of CPT Code 99223), the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the hospital visit and consult codes.

Specialty: Calculated data: American Society of Internal Medicine, American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association, American College of Cardiology, American College of Rheumatology, American Academy of Neurology, American Academy of Pain Medicine, American Geriatrics Society, American Nurses Association, and American Academy of Physician Assistants

Public Comments

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Code: 99261

1995 RVUs: 0.36

Recommended RVUs: Inc

Ratio:

Long Descriptor: Follow-up inpatient consultation for an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n): N Global Period: XXX Frequency: 1,144,044 Impact:

Source: 7 Year: 93 Public Comment Letter: 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACOG, ACRh, ACS, AGS, ANA, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99261	55.6	17	15.4	57.2	9	0.9	2.4	9.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99261	1746885	1325166	-12.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99261	96.8	96	-0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99261	cardiovascular disease	11.3
	gastroenterology	6.6
	general surgery	6.6
	general/family practice	6.1
	internal medicine	25.9
	neurology	7.1
	pulmonary disease	4.8

Public Comments

06-Jul-95

urology	4.1
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Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
99261		
250	1.9	DIABETES MELLITUS
401	2.1	ESSENTIAL HYPERTENSION
414	1.5	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	1.7	CARDIAC DYSRHYTHMIAS
428	1.5	HEART FAILURE
780	1.2	GENERAL SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99261							
ACP		XXX	XXX	0.45	0.36	0.80	0.47

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99261								
ACP	0.38	0.36	1.04	0.81	0.95	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99261								
ACP	XXX	0.45				10		2

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99261									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99261									
ACP				INCR	0.36	xx	n		0.042

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Code: 99263

1995 RVUs: 1.16

Recommended RVUs: Inc

Ratio:

Long Descriptor: Follow-up inpatient consultation for an established patient which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 757,938 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, AGS, ASIM

Societies Wishing to Comment: AACAP, AAPMR, ACCP, ACOG, ACRh, ACS, ANA, AOA, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99263	56.5	18.1	16.2	55.1	8.9	1.1	2.2	5.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99263	771617	845712	4.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99263	95.6	94.5	-0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99263	cardiovascular disease	16.2
	gastroenterology	4.3
	infectious disease	5.6
	internal medicine	22.7
	nephrology	4.1
	neurology	12.4
	psychiatry	7.7

Public Comments

06-Jul-95

pulmonary disease	6.5
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Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99263			
	250	1.5	DIABETES MELLITUS
	276	1.1	DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE
	401	1.8	ESSENTIAL HYPERTENSION
	414	1.7	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
	427	2.1	CARDIAC DYSRHYTHMIAS
	428	2.5	HEART FAILURE
	518	1.5	OTHER DISEASES OF LUNG
	780	1.7	GENERAL SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99263							
ACP		XXX	XXX	1.32	1.16	0.88	1.34

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99263								
ACP	1.18	1.16	1.02	0.88	0.98	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99263								
ACP	XXX	1.32				30		6

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	lcuvis	Offvis
99263									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99263									

Public Comments

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ACP	INCR	1.16	xx	n	0.040
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**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 99262 Global Period: XXX Current RVW: 0.74 Recommended RVW: 1.3

CPT Descriptor: Follow-up inpatient consultation for an established patient which requires at least two of these three key components:

1. an expanded problem focused interval history;
2. an expanded problem focused examination; and
3. medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

Source and Summary of Comment to HCFA on this service: ASIM, ACP, AAFP, AAP and others on hospital evaluation and management services in general. Patients' hospital stay has decreased and they are being discharged from the hospital in a more unstable condition than five years ago. Consequently, intensity of physician work in the hospital has increased over the past five years. Post-service work has also increased over the past five years. Finally, current intra-service intensities are much lower for evaluation and management codes than other services.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Follow-up inpatient consultation with 51 year old male for evaluation and determination of the etiology of postoperative hyponatremia following TURP. (ASIM/ACP/AAFP/AOA)

Follow-up inpatient consultation for an 8 year old male who develops a maculopapular skin rash 48 hours after initiation of an antibiotic therapy for pneumonia and dehydration. (AAP/AOA)

Follow up inpatient consultation for a 65 year old man with a history of hypertension and MI who is five days post uncomplicated GI procedure with a [heretofore] unremarkable postoperative recovery. He has just been resuscitated from a cardiopulmonary arrest. (ACC)

Follow-up inpatient consultation for a 22 year old female, established patient, with steroid-dependent systemic lupus erythematosus, arthritis, and glomerulonephritis. (ACR)

Follow-up hospital consultation for a 71 year old male with progressive dementia to review requested studies which reveal no treatable cause of dementia and to have brief initial discussion with the patient and family present concerning Alzheimer's disease. (AAN)

Follow-up inpatient consultation for a 30 year old established patient, with intractable neck and low back pain, who is excessively sedated after institution of methadone therapy. (AAPM)

Description of Pre-Service Work:

Pre-service work includes preparing to see the patient, reviewing records, and communicating with other professionals, as appropriate. (ALL)

Description of Intra-Service Work:

Expanded problem focused interval history, including review of lab results. Expanded problem focused exam, including fluid status and mentation. Medical decision making of moderate complexity, including revision of treatment plan and discussion with urologist. (ASIM/ACP/AAFP/AOA)

Examination reveals exanthem typical of roseola. Laboratory work and radiological studies are ordered and reviewed. (AAP/AOA)

The physician performs an expanded problem focused interval history and expanded problem focused physician examination including abdomen flanks, heart, lungs and extremities; and neurologic system including cerebral function. Prognosis and alternative approaches to diagnosis and therapy are discussed with the family, and if possible, the patient. Medical decision making is of high complexity and involves ordering ventilation perfusion study to confirm or rule out pulmonary embolus, possible Doppler exam of legs to assess thrombophlebitis, decision regarding thrombolytics, anticoagulants, or other appropriate medical therapy. (ACC)

The patient's recent hospital course and lab studies are reviewed. An expanded problem focused examination is performed and MRI, EKG, and V/Q scan are ordered. A conference is held with other attending physicians. (ACR)

CPT Code 99262

Includes an expanded problem focused interval history, expanded problem focused examination, and medical decisionmaking of moderate complexity. (AAN)

Physician performs an expanded problem focused interval history (may include discussions with family) and an expanded problem focused physical and neurological examination to detect any changes from intractable pain baseline status. Medical decisionmaking is of moderate complexity due to excessive sensation. Pharmacologic adjustments are made using many different classes of pharmacologic agents. (AAPM)

Description of Post-Service Work:

Post-service work includes all coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals, associated with the delivery of care to this patient until the next face-to-face E/M service is provided (excluding care plan oversight of more than 30 minutes per month for home health and hospice patients). (ALL)

SURVEY DATA:

Specialty: Combined data: American Society of Internal Medicine, American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association, American College of Cardiology, American College of Rheumatology, American Academy of Neurology, and American Academy of Pain Medicine

Sample Size: 169/981 Response Rate (%): 17% Weighted Median RVW: 1.3

25th Percentile RVW: 1.0 75th Percentile RVW: 1.8 Low: 0.05 High: 4.82

Median Pre-Service Time: 10 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 30 minutes

Low Intra-Svc Time: 5 minutes High Intra-Svc Time: 100 minutes

Median Post-Service Time: 30 minutes

Elements of Post Time:

Median time for documentation of the service provided: 5 minutes

Median time for arranging for further services: 15 minutes

Median time for reviewing results of studies: 5 minutes

Median time for communicating further with patient, family, and other professionals including reports: 10 minutes

Median time for providing written or telephone reports to Medicare or other third party payers: 5 minutes

Median time for providing care plan oversight services less than 30 minutes per month: X minutes*

* Care plan oversight was not included on most survey reporting forms.

Work Changed?: Complexity: Increased: 82.8% Decreased: 0% Same: 17.2%

Oversight: Increased: 80.6% Decreased: 2.2% Same: 17.2%

Documentation: Increased: 88.2% Decreased: 2.2% Same: 9.6%

Vignette Typical?: Yes: 89.8% No: 10.2%

CPT Code 99262

Demographics (who responded): General internists: 20 Family physicians: 47
 Pediatricians: 26 Neurologists: 26 Pain management: 15 Internal Medicine Subspecialists: 35

Breakdown by Subspecialty: Cardiology 9, Rheumatology 14, Endocrinology 2, Pulmonology 2, Allergy 2,
 Gastroenterology 2, Nephrology 3, Infectious Disease 1.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99283	Emergency Dept Visit	1.07
2)	99282	Emergency Dept Visit	0.47
3)	62270	Spinal Fluid Tap, Diagnostic	1.13
4)	12002	Repair Superficial Wounds	1.81

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the services you are rating to the key reference services listed above.

According to the survey respondents, mental effort is higher for 99262, lower for technical skill, and about the same for psychological stress, when compared to 12002. Pre time and post time are both higher for 99262, but the intra time was rated about the same as 12002. It is true that the technical skill involved with laceration repair is more complex than the followup consult, but the consult requires more mental effort and pre and post-service time than for such a simple procedure. The followup consultation requires that lab results be checked, more documentation, communication with the patient and patient's family, and communication with the referring physician.

The components of work and time were measured to be very similar to 62270 (1.13 RVWs), except for mental effort and post-service time, which were higher for 99262. The major mental effort involved with a spinal tap is the decision to perform the tap, not the act of performing the tap itself, hence mental effort for a followup consultation is much higher. Post-service time for the consultation followup is also much higher than a bedside procedure, both require checking lab results, but documentation, communication with the patient and patient's family, and communication with the referring physician are more extensive for the consultation followup.

The survey respondents rated 99262 similar to 99283 emergency room visit, except that the mental effort and post-service time is higher for 99262. Compared to 99282, 99262 is rated higher across the board, except for psychological stress, which is slightly lower. The greater complexity of a patient warranting a consultation followup is what confers the additional work as compared to an emergency room visit, whether it is at the second or third level.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The organizations surveying evaluation and management (E/M) codes recommend that the RVW be increased from the current level to 1.3. The combined median RVW was 1.25, but a weighted median of 1.3 based upon the RVW estimates of specialties that perform the service most often (see comments on codes 99253 and 99255) and because of the time estimates, a slightly higher RVW was justified to bring intra-service intensities in line with the RVW recommendations of other E/M services.

CPT Code 99262

The combined median total time estimates for this service (60 minutes) is more than double the current assumed time of 24 minutes. The combined median post time estimate of 30 minutes is nearly eight times higher than the current estimate of 4 minutes. Post-service time has increased substantially in recent years because of the increase in documentation; more time spent tracking down information while the patient is in the hospital; more time spent discussing treatment options with the patient, family, and the primary care physician; because physicians are working with frailer patients than five years ago and because of the compression of the hospital stay. The intra-service time estimates were very similar to the current assumption of 20 minutes.

Like other consultative services in the hospital, the average hospitalized patient has more problems, some of which maybe unstable, requiring more complex evaluations and procedures to be performed. Consultations are not requested as often as they were five years ago because of the implementation and changes in utilization review criteria. Thus, when a followup consultation is requested, the work involved is greater than five years ago.

Because of the inconsistency in the survey instrument (see "rationale" of CPT Code 99223), the definition of intra-service time may have been unclear to the survey respondents. Therefore, CPT intra-service time was utilized to more accurately redistribute the median surveyed pre-, intra-, and post-service time in order to calculate intra-service intensity. In order to maintain consistency in the calculations of intra-service intensity, the CPT intra-service time was subtracted from the sum of the surveyed median pre-, intra-, and post-service times to determine the consensus pre- and post-service time that were used in the intra-service intensity calculations. This rationale applies to all of the hospital visit and consult codes.

Public Comments

06-Jul-95

Code: 99262

1995 RVUs: 0.74

Recommended RVUs: Inc

Ratio:

Long Descriptor: Follow-up inpatient consultation for an established patient which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 1.695,504 **Impact:**

Source: 7 **Year:** 93 **Public Comment Letter:** 297

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFP, AAN, AAP, AAPM, ACP, ACR, AOA, ASIM

Societies Wishing to Comment: AACAP, AAO-HNS, AAPMR, ACCP, ACOG, ACS, AGS, ANA, AOA-HCPAC, APA, APA-HCPAC, APMA, ASCRS, ASRM 2, ATS, AUA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99262	58	18.8	16.7	56.1	9	0.8	2.1	6.9

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99262	2187790	1934955	-6

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99262	96.4	95.8	-0.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99262	cardiovascular disease	14.8
	gastroenterology	5.4
	general surgery	3.4
	general/family practice	4.6
	internal medicine	25.7
	neurology	4.2
	neurology	9.9

Public Comments

06-Jul-95

pulmonary disease	7.8
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Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
99262			
	250	1.9	DIABETES MELLITUS
	401	2.1	ESSENTIAL HYPERTENSION
	414	1.9	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
	427	1.9	CARDIAC DYSRHYTHMIAS
	428	2.1	HEART FAILURE
	496	1.1	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
	780	1.4	GENERAL SYMPTOMS
	786	1.1	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Peck95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99262							
ACP		XXX	XXX	0.89	0.74	0.83	0.91

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99262								
ACP	0.76	0.74	1.02	0.84	0.97	1.00	INCR	297

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99262								
ACP	XXX	0.89				20		4

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99262									
ACP									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99262									

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ACP	.	INCR	0.74	xx	n	0.041
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Society of Critical Care Medicine

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 99291 Global Period: 0 Current RVW: 3.64 Recommended RVW: 4.00

CPT Descriptor: Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; first hour.

Source and Summary of Comment to HCFA on this service: Survey of critical care physician members of the Society of Critical Care Medicine, American College of Emergency Physicians, American Thoracic Society and American College of Chest Physicians.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: First hour of critical care of a 65-year old woman who, following a hysterectomy, suffered a cardiac arrest associated with a pulmonary embolus.

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Critical care is the care of critically ill and unstable patients who require constant physician attention due to the patient's acute circumstances. Care of these patients involves decision making of high complexity and extensive interpretation of multiple databases to prevent or combat single or multiple organ system failure. Critical care services are provided to critically ill and unstable patients who include, but are not limited to, patients with central nervous system failure, circulatory failure, shock-like conditions, renal or respiratory failure, postoperative complications or overwhelming infection. The acute, unstable nature of the patient is the focus of the physician's efforts as he/she works quickly to develop a patient history/physical assessment and diagnostic data for interpretation. The physician quickly stabilizes the patient and conducts a number of invasive and non-invasive procedures, including CPR; fluid resuscitation; antibiotic therapy; interpretation of cardiac output measurements; chest x-rays; blood gases and information data stored in computers (eg blood pressures, hematologic data; gastric intubation; temporary transcutaneous pacing; ventilator management; and vascular access procedures. The physician coordinates all diagnostic procedures and the efforts of appropriate consultants, when the patient's condition necessitates their involvement.

Description of Post-Service Work: N/A



Society of Critical Care Medicine

CPT Code: 99291

SURVEY DATA:

Specialty: Critical Care Medicine

Sample Size: 155 Response Rate (%): 48%* Median RVW: 4.00

25th Percentile RVW: 4.00 75th Percentile RVW: 4.20 Low: 3.00 High: 11.45

Median Pre-Service Time: 20 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 60 Low: 30 High: 240

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>N/A</u>	<u>N/A</u>
Other Hospital:	<u>N/A</u>	<u>N/A</u>
Office:	<u>N/A</u>	<u>N/A</u>

*Excludes 15 incomplete surveys that were disqualified from evaluation.



KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	92950	Cardiopulmonary resuscitation (eg, in cardiac arrest)	3.80
2)	99255	Inpatient consultation for a new or established patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.	3.14
3)	99285	Emergency department visit for the evaluation and management of a patient, which requires these three components within the constraints imposed by the urgency of the patient's clinical condition and mental status: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	2.63

4)



Society of Critical Care Medicine

CPT Code: 99291

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Please see attached information.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Please see attached information.



Society of Critical Care Medicine

CPT Code 99291

Key Reference Services:

		RVW
92950	Cardiopulmonary resuscitation	3.80
99255	Initial inpatient consultation	3.14
99285	Emergency department visit	2.63

Relationship of code being reviewed to key reference services:

Results of the survey demonstrated a very high intensity level for critical care, with average scores for mental effort and judgment; technical skill and physician effort; and psychological stress being 4.8; 4.4267; and 4.6 respectively. The respondents believed that critical care services were more intense than the reference services. The scores for CPR, by far the most frequently mentioned reference service, for the above-mentioned categories were 4.1; 4.1; and 4.568; for initial inpatient consultation the scores were 3.533; 3.429; and 3.267; for the emergency department visit the scores were 4.375; 3.75; and 4.0.

Median intra-service time for critical care (60 minutes) also was greater than that for all the reference services above, including double the median intra-service time for CPR and the emergency department visit, both of which had median times of 30 minutes. The median intra-service time for the initial inpatient consultation was 52.5 minutes. This is close to the median intra-service time for critical care. However, it should be noted that the intensity measurements for the inpatient consultation were far lower than those for critical care. Critical care is defined as a "hands on" code. Therefore, comparisons of pre- and post-service times are not applicable.

Rationale:

Members of the four different specialty societies participated in the survey process for critical care services — the Society of Critical Care Medicine, the American College of Chest Physicians, the American College of Emergency Physicians and the American Thoracic Society. The number of respondents (77) reflects a significant consensus of opinion among the societies that the physician work for the initial hour of critical care services per day should be valued at 4.0 for physician work.

A large majority of the respondents felt that 4.0 was an appropriate RVW for critical care, as evidenced by the median RVW being 4.00, the 25th percentile RVW being 4.00, and the 75th percentile being 4.20. In addition, the most frequently used reference service, 92950, which appears on HCFA's multispecialty reference list, has an RVW of 3.8. As has been discussed above, the survey results confirm that critical care is a more intense service than 94950 and requires more than twice the time, on average. The other reference services — 99255 and 99285 — are also on HCFA's multispecialty reference list.

A vast majority of the respondents believe that care for the typical patient has changed and that the patient has become more complex.

Of those choosing to answer the questions regarding whether the patients requiring critical care services are more complex, 92% believe that the patients are more complex, 8% believe there has been no change. No one responded that the patients are less complex.

Public Comments

06-Jul-95

Code: 99291

1995 RVUs: 3.64

Recommended RVUs: 3.64

Ratio:

Long Descriptor: Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; first hour

Reference Set (y/n): Y Global Period: XXX Frequency: 1,441,604 Impact: 0

Source: 11 Year: 94 Public Comment Letter: 80

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAN, ACCP, ACEP, ATS, SCCM

Societies Wishing to Comment: AACAP, AAFF, AAP, AAPMR, ACC, ACOG, ACRh, ACS, AGS, ANA, AOA, APA, APA-HCPAC, APMA, APSA, ASA, ASIM, RPA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99291	51.1	13.8	15.4	50.9	8.9	0.8	2.7	8.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
99291	1550633	1637841	2.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99291	88.9	89.6	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
99291	cardiovascular disease	12.4
	critical care	4.6
	emergency medicine	5.7
	general surgery	2.8
	general/family practice	9.8
	group practices	4.5
	internal medicine	29.5
	pulmonary disease	18.8

Claims-Level Diagnosis Information:

Public Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
99291		
410	2.2	ACUTE MYOCARDIAL INFARCTION
414	2	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	3.4	CARDIAC DYSRHYTHMIAS
428	3.8	HEART FAILURE
486	1.7	PNEUMONIA, ORGANISM UNSPECIFIED
496	1.8	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
518	6.4	OTHER DISEASES OF LUNG
786	1.9	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhrv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99291							
ACEP			XXX	.	3.64	.	2.36
NAMDRC			XXX	.	3.64	.	2.36
SCCM			XXX	.	3.64	.	2.36

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
99291								
ACEP	3.67	3.64	.	1.56	0.99	1.00	7.00	320
NAMDR C	3.67	3.64	.	1.56	0.99	1.00	3.64	80
SCCM	3.67	3.64	.	1.56	0.99	1.00	4.00	255

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	htime	Notett	Imppt
99291								
ACEP	XXX	.	.	.	.	60	.	.
NAMDRC	XXX	.	.	.	.	60	.	.
SCCM	XXX	.	.	.	.	60	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99291									
ACEP									

Public Comments

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NAMDR
C
SCCM

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
99291									
ACEP				7.00	3.64				
NAMDR				3.64	3.64				
C									
SCCM				4.00	3.64				



Society of Critical Care Medicine

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 99292 Global Period: 0 Current RVW: 1.84 Recommended RVW: 2.00

CPT Descriptor: Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; each additional 30 minutes.

Source and Summary of Comment to HCFA on this service: Survey of critical care physician members of the Society of Critical Care Medicine, American College of Emergency Physicians, American Thoracic Society and American College of Chest Physicians.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: One-half hour segments of critical care of a 65-year old woman who, following a hysterectomy, suffered cardiac arrest associated with a pulmonary embolus.

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Critical care is the care of critically ill and unstable patients who require constant physician attention due to the patient's acute circumstances. Care of these patients involves decision making of high complexity and extensive interpretation of multiple databases to prevent or combat single or multiple organ system failure. Critical care services are provided to critically ill and unstable patients who include, but are not limited to, patients with central nervous system failure, circulatory failure, shock-like conditions, renal or respiratory failure, postoperative complications or overwhelming infection. The acute, unstable nature of the patient is the focus of the physician's efforts as he/she works quickly to develop a patient history/physical assessment and diagnostic data for interpretation. The physician quickly stabilizes the patient and conducts a number of invasive and non-invasive procedures, including CPR; fluid resuscitation; antibiotic therapy; interpretation of cardiac output measurements; chest x-rays; blood gases and information data stored in computers (eg blood pressures, hematologic data; gastric intubation; temporary transcutaneous pacing; ventilator management; and vascular access procedures. The physician coordinates all diagnostic procedures and the efforts of appropriate consultants, when the patient's condition necessitates their involvement.

Description of Post-Service Work: N/A



Society of Critical Care Medicine

CPT Code: 99292

SURVEY DATA:

Specialty: Critical Care Medicine

Sample Size: 155 Response Rate (%): 49% * Median RVW: 2.0

25th Percentile RVW: 2.0 75th Percentile RVW: 2.38 Low: 1.50 High: 10.00

Median Pre-Service Time: N/A Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 30 Low: 12 High: 120

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	
ICU:	<u>N/A</u>	<u>N/A</u>
Other Hospital:	<u>N/A</u>	<u>N/A</u>
Office:	<u>N/A</u>	<u>N/A</u>

*Excludes 15 incomplete surveys that were disqualified from evaluation.



Society of Critical Care Medicine

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	31500	Intubation, endotracheal, emergency procedure	2.38
2)	36625	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown	2.11
3)	99291	Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; first hour.	3.64
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Please see attached information.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Please see attached information.



Society of Critical Care Medicine

CPT Code 99292

Key Reference Services:

		RVW
31500	Insertion emergency airway	2.33
36625	Insertion, catheter, artery	2.11
99291	Critical care, initial hour	4.00*

*Recommended RVW

Relationship of code being surveyed to key reference services

The key reference service is 99291, critical care, initial hour. Survey respondents scored the mental effort and judgment; technical skill and physician effort; and psychological stress almost identical to those factors for 99291. The average scores for 99292 were 4.7; 4.42; and 4.57 respectively. Since 99292 is used only when critical care services are required for more than 74 minutes, one would expect the intensity for the two services to be about the same. The median intra-service time for 99292 was 30 minutes as compared to 60 minutes for 99291.

Rationale:

Members of the four different specialty societies participated in the survey process for critical care services — the Society of Critical Care Medicine, the American College of Chest Physicians, the American College of Emergency Physicians and the American Thoracic Society. The number of responses (76) reflects a significant consensus of opinion among the societies that the subsequent half-hour segments of critical care services per day should be valued at 2.0 for physician work.

A large majority of the respondents felt that 2.0 was an appropriate RVW for critical care, as evidenced by the median RVW being 2.00, the 25th percentile being 2.00 and the 75th percentile being 2.38. The other reference services mentioned frequently on the survey responses — other than 99291 — have values close to 2.00.

A vast majority of respondents believe that care for the typical patient has changed and that the care for the critically ill or injured patient has become more complex.

Of those choosing to answer the questions regarding whether the patients requiring critical care services are more complex, 91.3% believe that the patients are more complex, 8.79% believe there has been no change. No one responded that the patients are less complex.

Public Comments

Code: 99292

1995 RVUs: 1.84

Recommended RVUs: 2.00

Ratio:

Long Descriptor: Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; each additional 30 minutes

Reference Set (y/n): Y Global Period: XXX Frequency: 576,487 Impact: 92238

Source: 11 Year: 94 Public Comment Letter: 255

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAN, ACCP, ACEP, ATS, SCCM

Societies Wishing to Comment: AACAP, AAFP, AAP, AAPMR, ACC, ACOG, ACRb, ACS, AGS, ANA, AOA, APA, APA-HCPAC, APMA, APSA, ASA, ASIM, RPA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
99292	54.3	14.5	15.6	50.5	8.6	0.8	2.1	10.5

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
99292	762057	674338	-5.9

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
99292	91.9	91.4	-0.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
99292	anesthesiology	2.2
	cardiovascular disease	12
	critical care	3
	emergency medicine	4.1
	general/family practice	13.3
	group practices	4.3
	internal medicine	36.2
	pulmonary disease	12.2

Claims-Level Diagnosis Information:

Public Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
99292		
250	1.9	DIABETES MELLITUS
410	3	ACUTE MYOCARDIAL INFARCTION
414	2.3	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	3.7	CARDIAC DYSRHYTHMIAS
428	4.8	HEART FAILURE
496	1.8	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
518	5.3	OTHER DISEASES OF LUNG
786	1.7	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packdv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
99292							
ACEP			XXX		1.84		1.19
NAMDRC			XXX		1.84		1.19
SCCM			XXX		1.84		1.19

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
99292								
ACEP	1.86	1.84		1.56	0.99	1.00	3.50	320
NAMDR C	1.86	1.84		1.56	0.99	1.00	1.84	80
SCCM	1.86	1.84		1.56	0.99	1.00	2.00	255

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
99292								
ACEP	XXX					30		
NAMDRC	XXX					30		
SCCM	XXX					30		

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
99292									
ACEP									

Public Comments

06-Jul-95

NAMDR	.	.	.	.	.	.	.	.	.
C	.	.	.	.	.	.	.	.	.
SCCM	.	.	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
99292									
ACEP				3.50	1.84				
NAMDR				1.84	1.84				
C									
SCCM				2.00	1.84				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 92014 Global Period: XXX Current RVW: 1.06 Recommended RVW: 1.27

CPT Descriptor: Ophthalmological services; medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits

Source and Summary of Comment to HCFA on this service:

CMD Comments:

Recommended RVUs: 0.94

Reference Codes: 99214

Rationale for Change: The services required for 92014 are listed under 92004. These services are no more than a physician provides for 99214 visit.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A 64 year old with a recent onset of decreased vision and a past history of cataracts and macular drusen."

Description of Pre-Service Work: Inclusion of history of the previous records. Review of correspondence by other medical providers regarding the individual case.

Description of Intra-Service Work: Examine and evaluate eye and ocular adnexa to include comprehensive history, both medical and ocular, external examination of the eye, ophthalmoscopy, and biomicroscopy. Gross visual fields and neurological evaluation. Often may include dilated fundoscopic evaluation. Initiation of a diagnostic and treatment plan which may include other special ophthalmological testing, consultations, laboratory and radiological services; prescription of medication and/or corrective lenses would be included. Counseling of the patient and detailed instructions on treatment plan.

Description of Post-Service Work: Completion of medical record; transmittal of information to the patient's general practitioner or others as indicated.

SURVEY DATA:Specialty: American Academy of OphthalmologySample Size: 103 Response Rate (%): 34 Median RVW: 1.4725th Percentile RVW: 1.10 75th Percentile RVW: 1.70 Low: 0.55 High: 3.80Median Pre-Service Time: 5 Median Intra-Service Time: 2425th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 3 Low: 0 High: 60

Median Post-Service Time:

Total TimeNumber of VisitsDay of Procedure: 9

ICU: _____

Other Hospital: _____

Office: _____

SURVEY DATA:Specialty: American Optometric AssociationSample Size: 70 Response Rate (%): 51 Median RVW: 1.4425th Percentile RVW: 1.20 75th Percentile RVW: 1.82 Low: 0.80 High: 2.80Median Pre-Service Time: 5 Median Intra-Service Time: 3025th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 35 Low: 15 High: 55

Median Post-Service Time:

Total TimeNumber of VisitsDay of Procedure: 10

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	99213	Office/outpatient visit, est	0.55
2)	99215	Office/outpatient visit, est	1.51
3)	99203	Office/outpatient visit, new	1.14
4)	99214	Office/outpatient visit, est	0.94

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

99213 – the 92014 contains all services described in 99214 and sometimes could even reflect a 99215 visit. In the measurement of technical skill, mental effort and psychological stress involved 92014 represents at least an increase of two and one-half times the 99213 level. All respondents referenced 99213 because it was the closest accepted reference set; however, the services are vastly different.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The AAO and AOA originally recommended linking the value of this procedure to the 1995 value of 99215 (1.51 RVWs). The surveyed intra-service time for these procedures did not support our assertion (92014 – 27 minutes and 99215 – 35 minutes). The CMD's suggested that this procedure is no more work than a 99214 and that 92014 be valued identically. We now accept that linkage while noting that the RUC's multi-disciplinary workgroup 5 has agreed to recommend an RVW of 1.27 for 99214. Therefore, we recommend an increase in the value of 92014 from 1.06 to 1.27 RVWs.

The RVWs per surveyed minute of intra-service time for 92014 are 0.47 (1.27/27). This is lower than the ratios for the other surveyed evaluation and management procedures (see Table 1 on the recommendation form for 92002).

CMD Comments

06-Jul-95

Code: 92014 1995 RVUs: 1.06 Recommended RVUs: 0.94 Ratio: -0.11

Long Descriptor: Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits

Reference Set (y/n): Y Global Period: XXX Frequency: 6,137,352 Impact: -736482.24

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
92014			
	99214 OFFICE/OUTPATIENT VISIT, EST	0.94	XXX

CMD Comment:

The services required for 92014 are listed under 92004. These services are no more than a physician provides for 99214 visit.

Societies Wishing to Survey: AOA-HCPAC

Societies Wishing to Comment: AAO, ACEP

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
92014	54.6	13.4	7.8	65.6	3.1	0.1	0.4	11.5

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
92014	5687892	6302535	5.3

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
92014	0.5	0	-0.2

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
92014		
	ophthalmology	81
	other nonphysician prov	18

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
92014			
	362	5	OTHER RETINAL DISORDERS
	365	4	GLAUCOMA

CMD Comments

366	13.8	CATARACT
367	2.3	DISORDERS OF REFRACTION AND ACCOMMODATION
379	2.7	OTHER DISORDERS OF EYE
V43	2.4	ORGAN OR TISSUE REPLACED BY OTHER MEANS

Harvard Data:

Comm	Modif	Packhrv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
92014							
CMD		XXX	XXX	1.06	1.06	1.00	1.06

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
92014								
CMD	1.06	1.06	1.00	1.00	1.00	1.00	0.94	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
92014								
CMD	XXX	1.06				37		19

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	lcuis	Offvis
92014									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
92014									
CMD				0.94	1.06	op	n		0.022

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Psychiatry

The RUC considered comments submitted to HCFA by the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) on psychiatric services. Both societies commented that the current RBRVS Medicare Fee Schedule has not preserved the original work value relationships developed by Harvard. It was noted that according to Harvard methodology, it is important to preserve the ratio of relative work between the service designated as the standard service and the other services on the specialty-specific scale. Therefore, if the relative value of the standard service is changed, all other values should be changed to preserve the original ratio of the standard to other services. In particular the societies noted that since the implementation of the fee schedule, HCFA has disregarded this relationship by changing the relative values of some psychiatry codes but not others, which has resulted in the failure to preserve the fundamental relationships to the standard code. The societies contend that this HCFA's failure to maintain the relative relationship among the psychiatric codes that were surveyed by Harvard has resulted in the undervaluation of the entire scale of psychiatric service relative work values. In addition the comment made about HCFA's departure from the Harvard methodology, the APA made five other specific comments: 1) psychotherapy services 90842, 90843, and 90844 represent three bundled services (continuing medical evaluation, medication management, and psychotherapy), 2) psychotherapy codes which are time dependent, especially 98044 have inappropriately low work values due to undervaluing of time as a dimension of work, 3) the nature of psychotherapy services has become more intensive since the development of the existing work values, 4) the pre and post work for psychiatric services is undervalued, and 5) CPT code 90844 is inappropriately linked to CPT code 99204. The APA argued in their comments that CPT code 90844 requires that the physician spend 45-50 minutes of face-to-face time with a patient. In contrast 99204 can routinely last less than 45 minutes.

Based on a combined survey of 250 physicians, clinical psychologists, and nurses, recommendations were presented on eighteen psychiatric codes.

In their comments to HCFA and during their presentation to the RUC, the APA used the following as compelling evidence to increase the RVUs of the psychiatric codes:

1) Patient type and mix has changed dramatically during the past five years. APA reported that prior to 1990 for the most part "stable" patients were seen in an office outpatient setting. Patients that were considered unstable, and otherwise hard to manage were treated as inpatients, allowing the physician to

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add= The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

coordinate with the hospital staff if necessary. In the past patients tended to seek treatment earlier and physicians were able to make referrals to psychiatrists earlier. The onset of managed care has increased the likelihood that many patients are referred to non-physician mental health providers, which has translated into psychiatrists treating only the severely ill patient.

2) Decreasing inpatient hospital has resulted in increased patient morbidity. Again APA noted that shifting insurance industry patterns have played a significant role in this. Although many insurance policies offer mental health coverage, the coverage is often very restrictive. For example, most policies have strict limits on the number of inpatient hospital days. Many managed care policies have shifted away from long term psychotherapy in favor of short intermittent treatment therapies.

3) Since many more patients are seen at an outpatient basis there is an increasing amount of coordination of care with other providers. The APA noted that the time spent dealing with coordination of care issues has resulted in an increase of physician pre and post service work.

4) During the past five years there has been the introduction of new, highly sophisticated neuroleptic and antidepressant medications. The APA noted that because of the advances in psychopharmacology, a greater number of individual psychotherapy patients will likely utilize such medications, which was not the case five years ago. The greater reliance on such medications has increased the complexity of the medical decision making during an individual psychotherapy visit. Many of these new drugs require constant monitoring, such as weekly blood monitoring in the case of Clorazil. The failure to appropriately monitor these drugs could result in adverse side effects and possibly death.

5) The psychotherapy codes have specific times incorporated into the CPT descriptor which do not accurately reflect the current practice of psychiatry. The APA noted that the practice of psychiatry has changed significantly since the psychotherapy codes were surveyed during the Harvard study therefore, the current RVUs should be increased to reflect this change.

For those codes for which an increase is recommended, the RUC believes that these five points provide a compelling argument for increasing the RVUs from their current levels. The RUC also concluded that the survey vignettes that the specialty society used describe the "typical patient" in 1995. In two instances the CMDs recommended lowering the current RVUs of psychiatric services, in both instances the RUC concluded that the specialty society has provided compelling evidence to maintain the current value of those codes.

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Code	Descriptor	95 RVU	Rec RVU	RUC/Rationale	Key
90801	Psychiatric interview	2.19	2.80	The APA noted that the patient mix is more difficult as easier patients are being seen in different venues and because patients who were formally hospitalized are being seen as outpatients. In terms of reference services CPT code 90801[Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances their informants will be seen in lieu of the patient)] is similar to the office consultation codes 99244[Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity] and 99245[Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity]. It was noted that in terms of time, 90801 is most similar to 99244 however 90801, requires more post-service time. The APA also noted that unlike the Evaluation and Management codes, there is not a higher level psychiatric interview code. The APA-HCPAC noted that 90801 is the only consultation code available to them since they cannot report E/M codes. In current practice many patients are referred by a physician or referring agency, and the physician must provide a written report and treatment plan to the referring physician or agency. The RUC believed that compelling evidence was presented to increase the current value of this service.	1
90820	Diagnostic interview	2.25	2.25	90820 is reported primarily by child and adolescent psychiatrists, in circumstances which the patient cannot communicate to the therapist by talking and instead uses toys or other objects to "interact". Although, this service is sometimes referred to as "play therapy", this code is a diagnostic service also reported for adults that cannot communicate with their physician. AACAP noted that this patient is typically stable. The RUC noted that although, child and adolescent psychiatrists report this code most often, this group did not survey the code. It was the consensus of the RUC that the current RVU of 2.25 be maintained on an interim basis until the AACAP completes a survey of this code.	2
90825	Evaluation of tests/records	0.97	0.97	The specialty society provided no compelling evidence to support their comment, so the RUC recommends that the current RVUs be maintained.	2

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Code	Descriptor	95 RVU	Rec RVU	RUC/Rationale	Key
90835	Special interview	2.82	2.82	The specialty society provided no compelling evidence to support their comment, so the RUC recommends that the current RVUs be maintained.	2
90842	Psychotherapy, 75-80 min	2.74	2.74	This code was added to CPT and reviewed by the RUC during the 1994 RUC cycle. The RUC recommendation was accepted by HCFA at that time. Therefore, the RUC recommended maintaining the current value of this procedure.	2
90843	Psychotherapy, 20-30 min	1.10	1.47	The APA reported that the Harvard study showed that the 30 minute psychotherapy visit was more intense per unit time than the 50 minute visit. This intensity results from the fact that the physician is providing the same services as in the 50 minute visit (90844) but within a shortened timeframe. This code has also been affected by the proliferation of managed care, in that the carriers view the 90843 as more cost effective than 90844 which has resulted in more physicians reporting 90843. The RUC agreed with the rationale presented by the specialty society to increase the current value.	1
90844	Psychotherapy 45-50 min	1.72	2.00	The APA reported that this service represents the common 50 minute psychotherapy visit. The specialty society noted that a higher work value for 90844 is supported by 80% of their survey respondents who reported that the work of associated with this service has changed over the past five years. Of these, over 75% of the survey respondents reported that the complexity of patient problems being seen in the office had the hospital has increased. Slightly over one-half of all respondents report that the usual site of service has shifted from the inpatient to the outpatient setting. The Medicare data supports this shift. The RUC agreed with the rationale presented by the specialty society to increase the current value.	1
90845	Medical psychoanalysis	1.78	1.78	The specialty society survey results supported maintaining the current RVU for 90845[Medical psychoanalysis]. The median RVU of the survey was 1.71 which is close to the current value of this procedure, and almost two-thirds of the survey respondents report that the work associated with this service has remained the same during the past five years. The RUC agreed with the rationale of the specialty society and supported maintaining the current value.	2
90846	Special family therapy	1.82	1.82	The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVU be maintained.	2

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Code	Descriptor	95 RVU	Rec RVU	RUC/Rationale	Key
90847	Special family therapy	2.19	2.19	<p>The specialty society recommended a value of 2.10 which is 4% lower than the current RVU and also represents the survey median for psychiatrists. The APA-HCPAC noted that they support maintaining the current value of 90847.</p> <p>In light of the survey results that were presented by APA, and the fact that HCFA felt that a 4% decrease in the value of this code would be too small to make. The RUC consensus was to maintain the current value.</p>	2
90853	Special group therapy	0.43	0.59	<p>The median survey result of 1.74 indicated that some of the survey respondents misunderstood that the rating should be based on the individual group member not the entire group. Because of this misunderstanding the survey results revealed a bi-modal distribution. To arrive at the recommended value of 0.59 the specialty society assumed that all respondents rating 90853 above 1.0 were rating the entire group and divided these values by the number of persons in the group (6 or 8 depending on the vignette) the new median would be 0.59. The specialty society also noted that 90849[Multiple-family group medical psychotherapy by a physician, with continuing medical diagnostic drug evaluation, and drug management when indicated] which was a reference service for this code has an RVU of 0.59 which was recently adopted by the RUC. The RUC agreed with the specialty society rationale to increase the current value of the code.</p>	1
90855	Individual psychotherapy	1.81	2.15	<p>The specialty societies noted that the recommendation of 2.15 was 4% lower than the survey median which was 2.23. The specialty societies also noted that most of the survey respondents agreed that the work of 90855 fell between the key reference service codes of 99244(2.23) and 99404(1.95). The RUC agreed with the specialty society rationale and accepted the recommendation to increase the value of 90855.</p>	1
90857	Special group therapy	0.43	0.43	<p>The specialty society noted that the median survey result of 2.00 indicated that some of the survey respondents misunderstood that the rating should be based on the individual group member not the entire group. Therefore the specialty society is recommending an RVU of 0.59 for this service in order to preserve the current relationship between 90853 and 90857. This increased work value was also supported by the majority of the survey respondents who reported that the work of this service has increased during the past five years. The RUC did not think that there was compelling evidence to raise the current RVU for this service.</p>	2

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Code	Descriptor	95 RVU	Rec RVU	RUC/Rationale	Key
90862	Medication management	0.95	0.95	<p>This code is reported when the physician is providing medication management only. Another physician or mental health provider is usually responsible for patient psychotherapy. The APA noted that provision of this service represents the most significant change in psychiatric practice, due to the new generation of available medications. The APA also noted that the median intra-service time from the survey of 25 minutes was close to the Harvard intra-service time which is 28 minutes.</p> <p>The RUC did not think that there was compelling evidence to raise the value of this code. However, they disagreed with the CMD recommendation to lower the value and also noted that the RUC is not the correct forum to deal with issues of Medicare fraud and abuse.</p>	2
90870	Electroconvulsive therapy	1.88	1.88	<p>The specialty society reported that their survey results for these codes were unreliable based upon : 1) low response rate, 2) wide variation in values, and 3) the inability of the respondent to select a reference service. The specialty society recommended a value of 2.19 for this 90870 code in order to preserve its relationship to 90844 because the Harvard study used 98044 as the anchor for the development of the relative values for the psychiatric codes. For code 98071 the specialty society recommended an RVU of 3.17, in order to preserve its current relationship to 98071. The RUC was not convinced that the work changed or was out of line with the relative values for this family of codes. Therefore, the RUC recommended maintaining the current RVUs of 90870 and 90871.</p>	2
90871	Electroconvulsive therapy	2.72	2.72		2
90880	Medical hypnotherapy	2.19	2.19	<p>Hypnotherapy is the application of hypnotic technique in the context of psychotherapy for the treatment of mental/behavioral disorders, and is also utilized for the control of pain and psychosocial disorders.</p> <p>Although APA commented to HCFA that they felt 90880 was overvalued, the survey results support maintaining the current value of 2.19 for this service. The survey median of 2.23 is almost the same as the current value and the data does not support the assertion that the service is overvalued. APA also noted that 63% of the survey respondents report that the work of this service has increased during the past 5 years due to the complexity of the patient. The volume of this procedure is very low, with a frequency of 11,166 in 1994, as this procedure is typically not reimbursed by HCFA. The RUC recommended maintaining the current value of this service.</p>	2

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Code	Descriptor	95 RVU	Rec RVU	RUC/Rationale	Key
90887	Consultation with family	1.48	1.48	<p>The CMDs commented that CPT code 99214[Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity], which takes on average 25 minutes, if spent counseling a family member or a patient, would have an RVU of 0.94. The CMDs do not believe that the work of 90887 is greater.</p> <p>The specialty societies noted that their recommendation was the same as the survey median of 2.00, which reflects the higher intensity of this service when compared to that of 99204(1.95). HCFA commented that although a better reference service for this code is an established office visit, in terms of time, the current value of this procedure 1.48 is appropriate.</p> <p>The RUC believes that the current value of this service is in line with the Harvard value for this code of 1.48 and the Harvard intra-service time of 65 minutes. The RUC also noted that the Harvard data on time for this code, refute the CMD assertion that this service would take 25 minutes. The RUC recommends maintaining the current RVU for this code.</p>	2

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CHANGES IN PSYCHIATRIC PRACTICE

A Five Year Review

The cost containment strategies adopted by public and private insurers in recent years (e.g., prospective payment and managed care) have significantly influenced the delivery of mental health services. These changes have led to an increase in the average severity level of patients treated. The following identifies major trends in psychiatric practice and their resulting impact on patient severity:

- **Decreasing inpatient admissions.** The cost containment efforts of many payers have focused on reducing utilization of inpatient services. Capitated payment methods and utilization review procedures have sought to ensure that only the most severely ill patients are hospitalized. This shift of moderately ill patients to outpatient settings has served to increase the severity of both the average inpatient and the average outpatient.
- An analysis of the Medicare Part B Analytic Dataset (BMAD) supports the finding that inpatient services represent a decreasing proportion of all psychiatric services (Lewin-VHI, 1995a). As shown in Exhibit 1, approximately 44 percent of all psychiatric services delivered to Medicare patients took place in an inpatient setting in 1988. By 1994 only 18 percent of services were inpatient-based. Between 1988 and 1993, utilization of inpatient psychiatric services increased by only 23 percent, while utilization of outpatient psychiatric services increased by over 250 percent.
- An analysis of private insurance claims reveals that this reliance on outpatient service settings is even more pronounced in aggressively managed insurance plans. In one representative managed care plan, only 4 percent of all psychiatric services were delivered in inpatient settings in 1994 (Lewin-VHI, 1995b).
- Research supports the hypothesis that this shift in treatment setting has resulted in an increase in the severity of the average inpatient. Carter, Newhouse, and Relles (1991) document that the average PPS-paid patient is getting "sicker" in terms of case mix as measured by DRG. Russell and Manning (1993) also present evidence that the average hospital patient actually got sicker after PPS, as less severely ill patients were shifted to outpatient care.

- **Decreasing average lengths of stay.** Despite the increasing severity of patients admitted to inpatient care settings, the average length of a hospital stay has decreased dramatically since PPS was instituted (Coulam and Gaumer, 1991; Gold et al, 1993).
 - Freiman, Ellis, and McGuire (1989) found that the shift to PPS reduced ALOS for psychiatric patients in Medicare about 15 percent.
 - Frank and Lave (1989) and Ellis and McGuire (1994) estimated a similar reduction in ALOS for psychiatric patients insured through state Medicaid programs.

Reductions in average length of stay have augmented the shift of moderately severe patients to outpatient care settings. As inpatient stays are shortened, more severely ill patients are discharged to ambulatory treatment settings sooner, increasing the severity level of the average outpatient.

- **Increasing utilization of non-physician providers and non-psychiatric physicians.** As patients are shifted from inpatient to outpatient settings, the utilization of providers who are not psychiatrists has increased.
 - In 1988, 87 percent of psychiatric services utilized by Medicare patients were provided by psychiatrists, as shown in Exhibit 2. By 1994, only 66 percent of these services were delivered by psychiatrists (Lewin VHI, 1995a).
 - During that six year period, utilization of psychiatrist-provided services rose by 84 percent, while utilization of psychologist-provided services grew over twice that amount, increasing nearly 170 percent (Lewin-VHI, 1995a).
 - An analysis of private insurance claims reveals that this reliance on non-physician providers is even more pronounced in aggressively managed insurance plans. In one representative managed care plan, psychiatrists delivered only 18 percent of all psychiatric services in 1994 (Lewin-VHI, 1995b).

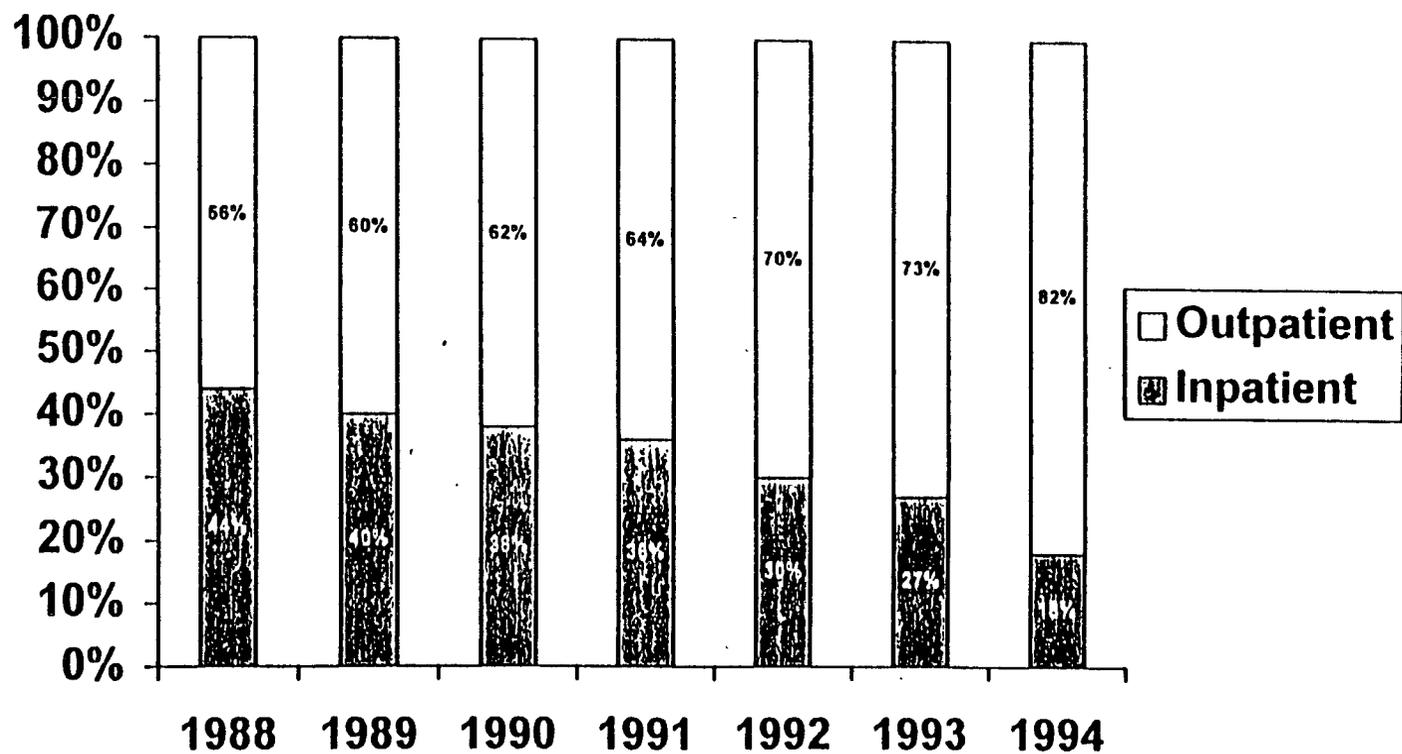
Although there has been an increasing reliance on non-physician providers of psychiatric services and non-psychiatric physicians, the bulk of the psychiatric services paid under the Medicare fee schedule are provided by psychiatrists. Thus, information about the complexity of the patients typically seen by psychiatrists is relevant to the development of appropriate work values for these services.

- Rodgers, et al (1993) found that the psychological sickness of patients of psychiatrists was approximately twice that of patients of psychologists/therapists or general medical clinicians.
- Wells et al (1995) also found that patients of psychiatrists tended to be the most psychologically sick.
- Psychiatrists continue to serve the vast majority of Medicare inpatients. In 1988, 90 percent of inpatient psychiatric services were provided by psychiatrists. By 1993, psychiatrists were still providing 80 percent of such services. As inpatients are likely the most severely ill psychiatric patients, on average the patients of psychiatrists are likely to be more severely ill than the patients of other providers (Lewin-VHI, 1995a).
- Despite the dramatic overall shift of patients from inpatient to outpatient treatment settings, psychiatrists only experienced a 30 percent decline in the proportion of Medicare services delivered in an inpatient setting, as shown in Exhibit 3. In contrast, psychologists experienced a 48 percent decrease in inpatient-based treatment delivery (Lewin-VHI, 1995a).

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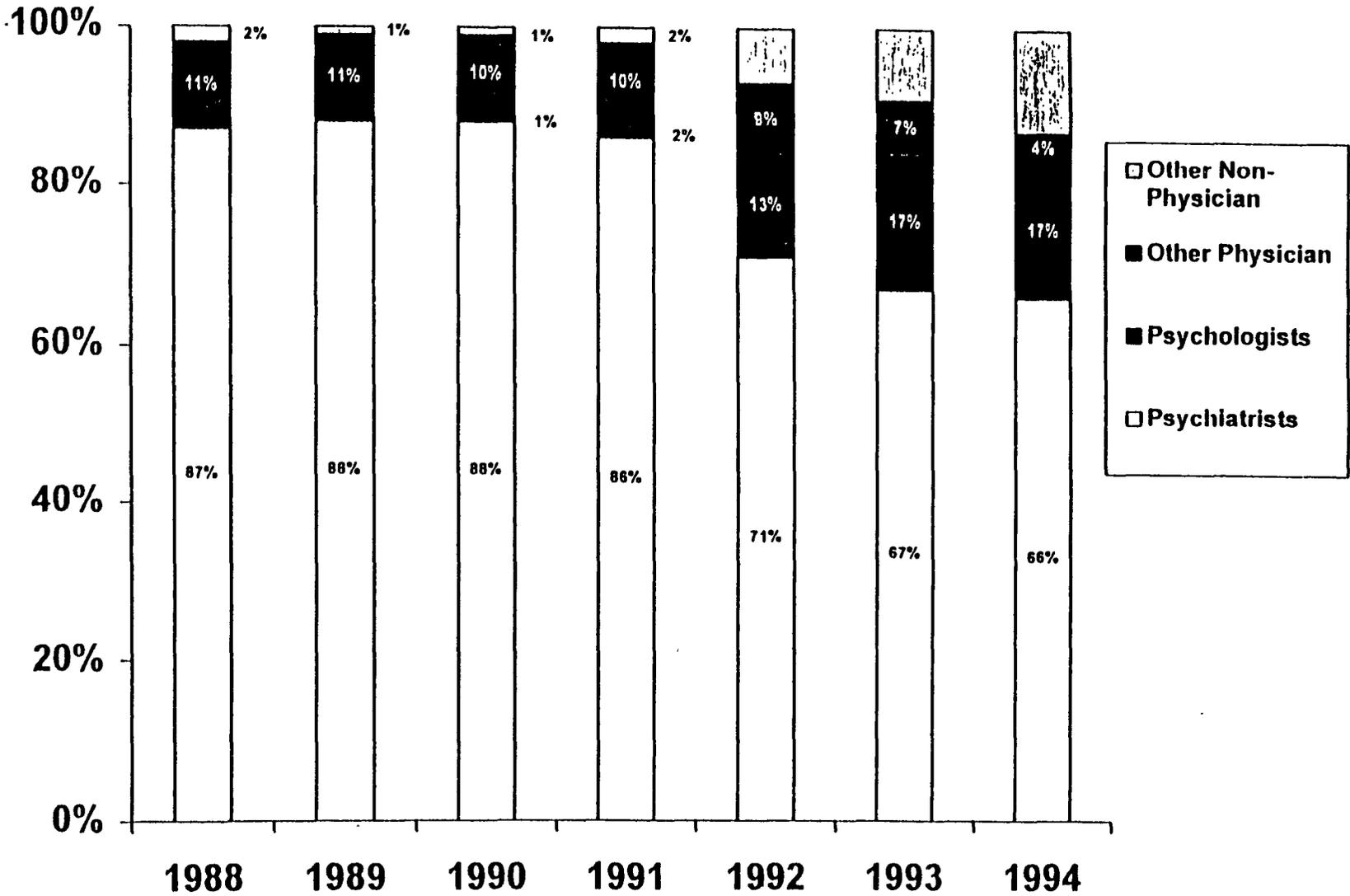
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**EXHIBIT 1:
PROPORTION OF PSYCHIATRIC
SERVICES BY TREATMENT SETTING**



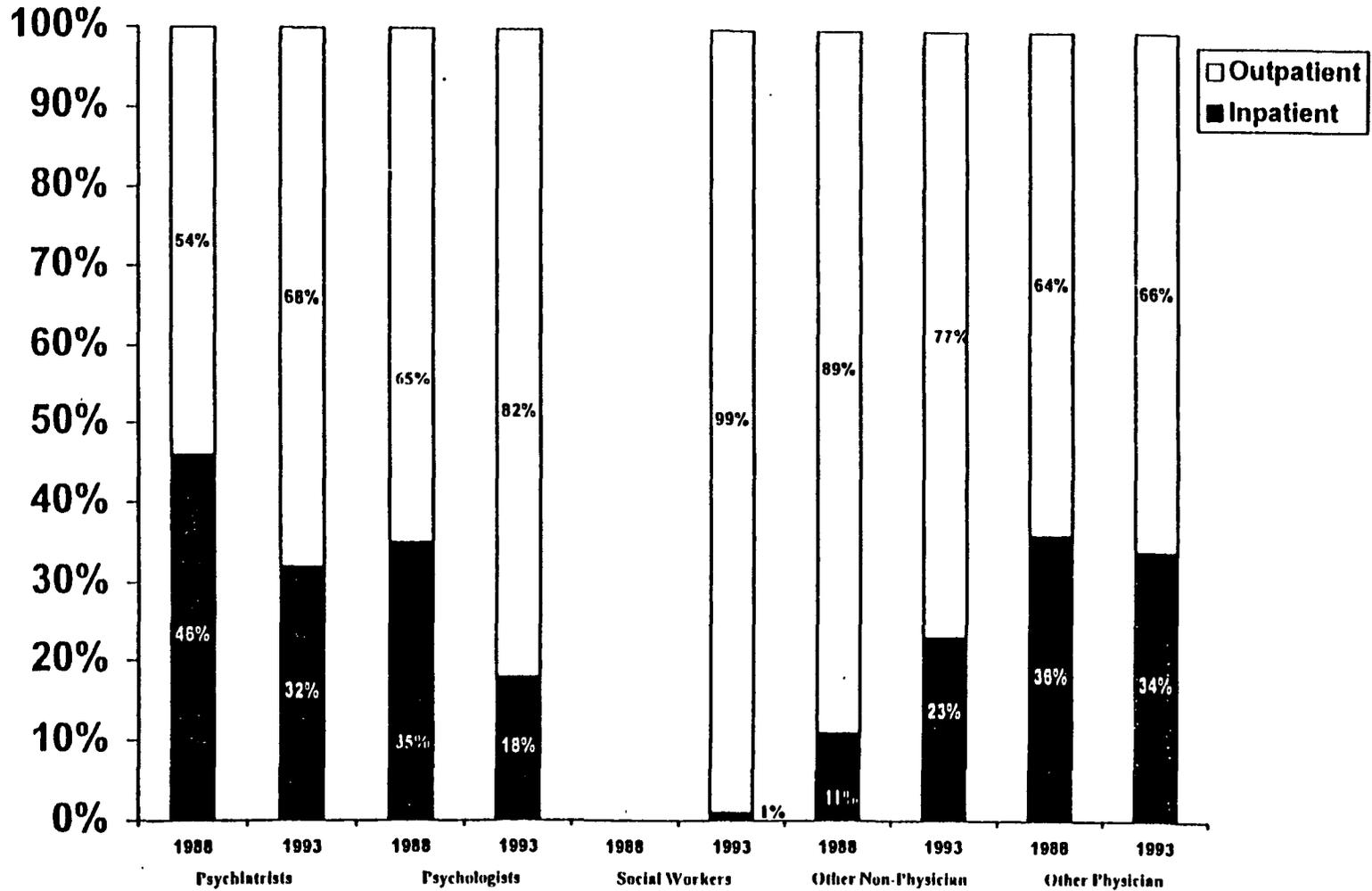
Source: Lewin-VIII analysis of the Medicare Part B Analytic Data Set (DMAD). Data includes services that are not reimbursed under the Medicare fee schedule.

**EXHIBIT 2:
PROPORTION OF PSYCHIATRIC
SERVICES BY PROVIDER TYPE**



Source: Lewin-VIII analysis of The Medicare Part B Analytic Data Set (BMAD). Data includes services that are not reimbursed under the Medicare fee schedule.

**EXHIBIT 3:
PROPORTION OF PSYCHIATRIC SERVICES
BY PROVIDER TYPE AND TREATMENT SETTING**



Source: Lewin-VIII analysis of The Medicare Part B Analytic Data Set (BAD). Data includes services that are not reimbursed under the Medicare fee schedule.

**SPECIALTY SURVEY RESULTS
MEDIAN RVU¹**

CPT CODE	AMERICAN PSYCHIATRIC ASSOCIATION		AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY		AMERICAN PSYCHOLOGICAL ASSOCIATION		AMERICAN NURSES ASSOCIATION		POOLED RESULTS		RECOMMENDED RVU
	#Responses	RVU	#Responses	RVU	#Responses	RVU	#Responses	RVU	#Responses	RVU	
90801	86	2.70	39	3.00	41	2.30	b		184	2.80	2.80
90820	35	2.50	a		b		b		77	2.23	2.80
90843	80	1.47	a		b		b		127	1.47	1.47
90844	85	1.95	35	2.30	48	1.80	b		188	2.00	2.00
90845	b		a		b		a		35	1.71	1.78
90847	63	2.11	a		a		b		83	2.00	2.19
90853	b		a		b		b		62	1.74	.59
90855	b		37	2.40	b		b		100	2.23	2.10
90857	b		a		b		b		33	2.00	.59
90862	80	1.30	38	1.44	a		b		136	1.30	1.30
90870	b		a		a		a		b		2.19
90871	b		a		a		a		b		3.17
90887	46	2.00	38	2.00	b		b		122	2.00	2.00

a - Did not survey this code.
b - Fewer than 30 responses.

¹ Does not include individual data for any code with fewer than 30 responses as the medians were deemed unstable. When pooled, all codes have responses above 30.
93KB0015 DOC

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 90801 Global Period: _____ Current RVW: 2.19 Recommended RVW: 2.80

CPT Descriptor:

Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants will be seen in lieu of the patient.)

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Vignette 1

- ◆ Evaluation session in office for 24 year old male who says he heard voices coming out of wall and was threatening to harm the neighbors.

Vignette 2

- ◆ The parents of a 15 year old boy ask for an evaluation for their son who was brought home by police after violating curfew and perhaps breaking and entering. They tell you he has a history of Attention Deficit and Hyperactivity Disorder (ADHD), has been suspended from school and has refused to take medicine for the past 6 months.

Description of Pre-Service Work:

Depends on how patient was referred. At a minimum requires phone discussion with person who initiated referral, e.g. physician, family, law enforcement, employer. Probably involves review of records from referral source and lab or consultation reports.

Description of Intra-Service Work:

Complete psychiatric history, including present illness, past history, family history, complete mental status examination, selected physical examination, making arrangements for laboratory tests. Establishing a definitive diagnosis or at least a narrow enough differential to warrant a treatment plan. Decision making concerning need for degree of supervision (e.g. hospitalization). Counseling with patient concerning diagnosis and options for treatment and proposed options.

Description of Post-Service Work:

Arrangement for further studies and further care. Report or discussion with referral source. Arrangement for getting additional information. Dictating results of examination. Frequently involves additional communication with patient and/or family after results of studies are known or to deal with side effects of instituted treatment. Would probably require information from collateral source regarding patient's compliance, accuracy of prediction that patient might remain on out-patient status, etc. Report and consultation with third party utilization manager to arrange for payment and funding for proposed treatment.

SURVEY DATA:

Specialty: Psychiatry (APA and AACAP), Psychology, Nursing

Sample Size: 523¹ Response Rate (%): 35%(184) Median RVW: 2.80

25th Percentile RVW: 2.25 75th Percentile RVW: 3.00 Low: 1.71 High: 9.00

Median Pre-Service Time: 10 Min. Median Intra-Service Time: 60 Min.

25th Percentile Intra-Svc Time: 50 75th Percentile Intra-Svc Time: 80 Low: 20 High: 300

Median Post-Service Time:	<u>Total Time</u>
Documentation of the service provided	<u>15</u>
Arranging for further services	<u>10</u>
Reviewing results of studies	<u>5</u>
Communicating further with patient, family, and other professionals including reports	<u>15</u>
Providing written or telephone reports to Medicare or other third party payors	<u>10</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99245	Office consultation, moderate to high severity (80 minutes)	2.96
2)	99244	Office consultation, moderate to high severity (60 minutes)	2.23
3)			
4)			

¹ The American Psychological Association sampled a total of 546 psychologists, of which 186 were targeted to this code.

90801

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90801	10	60	55	4	4	4
99245	10	80	60	4	4	4
99244	10	60	45	4	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A recommended RVU value of 2.80 is supported by the survey results. Moreover, the relationship of 90801 to the two most common reference services in terms of time and intensity also supports the value. Survey respondents find that 90801 takes more time than 99244 but less time than 99245. It is also of higher intensity than 99244 with a work value of 2.23 and of equal intensity to 99245 with a work value of 2.96. Given the survey results of 90801 in relationship to the two reference services, a value of 2.80 is appropriate. It is important to note that our reference services are EM codes that are subject to review. To the extent that the values of either of these reference services changes as part of the five year review, consideration should be given to altering the psychiatric values that were derived from those reference values.

The work entailed in conducting a diagnostic interview has increased significantly over the past five years. Patients being seen for a diagnostic interview are usually referred from other providers for a psychiatric evaluation. These patients often do not want to be seen by a mental health professional and the provider has only the time with the patient to render a diagnosis and prepare a treatment plan. Five years ago, many of these patients were hospitalized and the provider had a longer period of time to make a diagnosis. Today, most of these services occur in the provider's office and the time and intensity of performing the service has increased.

A higher work value for 90801 is also supported by 91 percent of survey respondents who report that the work associated with the service has changed over the past 5 years. Of these, 85 percent report that the complexity of patient problems being seen in the office and in the hospital has increased. About 60 percent report that the usual site of service for this code has changed from the inpatient to outpatient setting. Medicare data support the shift from inpatient to outpatient care for this code. From 1988 to 1994 the proportion of this service being done in the inpatient setting declined by 50 percent, while the proportion of the service being performed in an outpatient setting increased from 56 percent to 80 percent. Finally, an overwhelming proportion of survey respondents report that the work of performing this service has increased in terms of coordinating with other health professionals (82 percent), documenting services (94 percent), and communicating with third-party payers (98 percent).

The majority (81 percent) of survey respondents consider the vignettes to be representative of their typical patients.

Public Comments

06-Jul-95

Code: 90801

1995 RVUs: 2.19

Recommended RVUs: 3.23

Ratio:

Long Descriptor: Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants will be seen in lieu of the patient)

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 768,743 **Impact:** 799493

Source: 7 **Year:** 93 **Public Comment Letter:** 295

Reference Services:

CMD Comment:

Societies Wishing to Survey: AACAP, AAP, ANA, APA, APA-HCPAC

Societies Wishing to Comment: ASIM, NASW

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90801	37.5	13.9	16.6	58	39.9	0.2	0.7	8.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90801	563999	833378	21.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90801	26.6	21	-2.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90801	group practices	3.2
	other nonphysician prov	6.6
	psychiatry	68.6
	psychology	17.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90801	290	3.3	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS

AMA/Specialty Society RVS Update Process

Public Comments

06-Jul-95

295	4.9	SCHIZOPHRENIC DISORDERS
296	7	AFFECTIVE PSYCHOSES
300	2.6	NEUROTIC DISORDERS
309	2.5	ADJUSTMENT REACTION

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90801							
APA		XXX	XXX	1.88	2.19	1.16	2.01

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90801								
APA	2.19	2.19	1.07	1.09	1.00	1.00	3.23	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
90801								
APA	XXX	1.88				50		38

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90801									
APA									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
90801									
APA				3.23	2.19	py	n		0.022

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90843 Global Period: _____ Current RVW: 1.10 Recommended RVW: 1.47

CPT Descriptor:

Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy approximately 20 to 30 minutes.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

- ◆ Obsessive compulsive 29 year old female on chlomipramine who begins to uncontrollably pull her hair out after she gets fired from her job. Last seen six weeks ago.

Description of Pre-Service Work:

Preparing to see patient. Review of records. Telephone call to mother to get collateral information on patient. Telephone call to managed care to arrange for coverage of visit.

Description of Intra-Service Work:

History of present illness and relation of changes in patient's situation to patient's past history. Mental status examination with follow up on changes since last mental status examination. Psychotherapy addressing patient's obsessive compulsive disorder, hairpulling behavior, and employment difficulties. Brief physical examination (examination of pupils, blood pressure) to determine if patient is taking medication appropriately. Arrangement for blood test. Regulation of medicine. Counseling about side effects, counseling about significant environmental factors contributing to evaluation of anxiety, interpretation of connection between present and past events.

Description of Post-Service Work:

Arranging next visit. Obtaining and reviewing lab results and communicating with patient. Communicating with family. Calling in new prescription. Dictating record. Three telephone calls to managed care firm to arrange for additional outpatient visits. If provided by a non-physician, it also includes consulting with a physician.

SURVEY DATA:Specialty: Psychiatry (APA), Psychology, NursingSample Size: 483¹ Response Rate (%): 26%(127) Median RVW: 1.4725th Percentile RVW: 1.14 75th Percentile RVW: 1.71 Low: .90 High: 5.92Median Pre-Service Time: 5 Median Intra-Service Time: 30 Min.25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 30 Low: 20 High: 180

Median Post-Service Time:	<u>Total Time</u>
Documentation of the service provided	<u>5</u>
Arranging for further services	<u>5</u>
Reviewing results of studies	<u>0</u>
Communicating further with patient, family, and other professionals including reports	<u>5</u>
Providing written or telephone reports to Medicare or other third party payors	<u>5</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99243	Office consultation (30 minutes)	1.47
2)	99203	Office visit (30 minutes)	1.14
3)	99244	Office consultation, moderate to high severity (60 minutes)	2.23
4)			

¹ The American Psychological Association sampled a total of 546 psychologists, of which 186 were targeted to this code.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental Effort	Technical Skill and Physical Effort	Psychological Stress
90843	5	30	20	3	3	3
99243	5	30	16	3	3	3
99203	5	30	26	3	3	2.5
99244	5	50	75	4	4	3.5

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A recommended RVU value of 1.47 is supported by the survey results and the relationship of 90843 to the reference services used to develop the RVU value. One-third of all respondents identified 99243 (RVU 1.47) as the reference service for 90843 and the survey results rated the two services as nearly identical in terms of time and intensity. The two other most common reference services used were 99203 (RVU 1.14) and 99244 (RVU 2.23). Respondents rated 90843 about the same time but higher intensity as 99203 and lower time and intensity than 99244. Based on the relationship of 90843 to the reference services, a value of 1.47 is appropriate. It was the median value of all the survey values and is below the mean value of the three reference services used to develop the RVU. It is important to note that our reference services are EM codes that are subject to change under the five year review. To the extent that the values of any of these reference services change as part of the five year review, consideration should be given to changing 90843 accordingly.

A higher work value for 90843 is also supported by the 78 percent of respondents who reported that the work associated with this service has changed over the past five years. Of these, three-quarters report that the complexity of patient problems being seen in the office has increased, while 78 percent report that the complexity of patient problems being seen in the hospital has increased. One-half of all respondents report that the usual site of service has shifted from the inpatient to the outpatient setting. Medicare data support this shift from inpatient to outpatient care for this code. In 1988, 45 percent of this service was performed in the inpatient setting and by 1994 this proportion has declined to 23 percent. Finally, an overwhelming proportion of respondents report that the work of performing this service has increased in terms of coordinating with other health professionals (74 percent); documenting services (90 percent); and communicating with third-party payers (95 percent).

The vast majority (80 percent) of respondents consider the vignette to be representative of their typical patients.

Public Comments

06-Jul-95

Code: 90843

1995 RVUs: 1.1

Recommended RVUs: 1.36

Ratio:

Long Descriptor: Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 3,349,787 **Impact:** 870945

Source: 7 **Year:** 93 **Public Comment Letter:** 295

Reference Services:

CMD Comment:

Societies Wishing to Survey: ANA, APA, APA-HCPAC

Societies Wishing to Comment: AACAP, AAP, NASW

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90843	29.3	9.1	14.2	59.1	47.6	0.1	0.5	10.5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90843	3473460	3650954	2.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90843	32.5	22.8	-4.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90843	group practices	3.7
	other nonphysician prov	5.7
	psychiatry	77.2
	psychology	10.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90843	290	1.7	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS

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295	6.3	SCHIZOPHRENIC DISORDERS
296	9.1	AFFECTIVE PSYCHOSES
300	2.9	NEUROTIC DISORDERS
309	1.4	ADJUSTMENT REACTION

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90843							
AACAP		XXX	XXX	0.79	1.10	1.39	1.01
APA		XXX	XXX	0.79	1.10	1.39	1.01

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90843								
AACAP	1.10	1.10	1.28	1.09	1.00	1.00	1.46	272
APA	1.10	1.10	1.28	1.09	1.00	1.00	1.36	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
90843								
AACAP	XXX	0.79	.	.	.	25	.	11
APA	XXX	0.79	.	.	.	25	.	11

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
90843									
AACAP
APA

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90843									
AACAP	.	.	.	1.46	1.10	py	n	.	0.023
APA	.	.	.	1.36	1.10	py	n	.	0.023

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90844 Global Period: _____ Current RVW: 1.72 Recommended RVW: 2.00

CPT Descriptor:

Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy; Approximately 45 to 50 minutes.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Vignette 1

- ◆ Office psychotherapy, 20th session, for 52 year old depressed female with recurring suicidal ideation who took an overdose seven months ago but who has been stable on anti-depressants for four months.

Vignette 2

- ◆ Office psychotherapy for a 12 year old boy with post traumatic stress disorder secondary to abuse.

Description of Pre-Service Work:

Preparing to see patient. Review of records. Review of assignments for cognitive therapy.

Description of Intra-Service Work:

Mental status examination with special focus on suicidal ideas and related factors. History of present events with emphasis on distorted thinking and conscious efforts to change thinking patterns. Interpreting present behavior to past patterns of behavior. Physical examinations related to medicine. Counseling concerning side effects of medicine.

Description of Post-Service Work:

Arranging next visit. Dictating report. Whatever contact is necessary with managed care to enable service to be paid. Occasionally requires telephone conversation with collateral informant or primary care physician, e.g. if recurrence of suicidal thoughts is suspected. Reviewing and communicating results of lab studies if done at this visit.

SURVEY DATA:Specialty: Psychiatry (APA, AACAP), Psychology, NursingSample Size: 523¹ Response Rate (%): 36%(188) Median RVW: 2.0025th Percentile RVW: 1.7 75th Percentile RVW: 2.23 Low: 1.16 High: 6.00Median Pre-Service Time: 5 Median Intra-Service Time: 50 Min.25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 50 Low: 10 High: 180Median Post-Service Time: Total TimeDocumentation of the service provided 5Arranging for further services 2Reviewing results of studies 1Communicating further with patient, family, and
other professionals including reports 5Providing written or telephone reports to
Medicare or other third party payors 5**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99244	Office consultation (60 minutes)	2.23
2)	99404	Counseling and/or risk factor reduction interventions (60 minutes)	1.95
3)	99204	Office visit (45 minutes)	1.71
4)	99243	Office consultation (40 minutes)	1.47

¹ The American Psychological Association sampled a total of 546 psychologists, of which 186 were targeted to this code.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90844	5	50	18	3.0	4.0	3.0
99244	5	50	28	4.0	3.75	3.0
99404	5	60	13	3.0	3.0	2.0
99204	5	45	20	3.0	3.0	2.0
99243	5	45	17	2.5	3.0	3.0

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A recommended RVU value of 2.00 is supported by the survey results and the relationship of 90844 to the reference services used to develop the RVU value. Over one-quarter of all respondents used 99244 (RVU 2.23) as the reference service for 90844 and the survey results rated the two services as nearly identical in terms of time and intensity (although 99244 was viewed as slightly longer and requiring higher mental effort). After 99244, three other common references were 99404 (RVU 1.95), 99204 (RVU 1.71), and 99243 (RVU 1.47). Respondents viewed each of these services as either requiring less time or being less intense than 90844. For example, 99404 which has an RVU of 1.95 was viewed as requiring about the same amount of time as 90844 but requiring less psychological stress. Given the relationship of 90844 to the reference services, we believe that an RVU value of 2.00 is appropriate for 90844. It is important to note that our reference services are EM codes that are subject to change under the five year review. To the extent that the values of any of these reference services change as part of the five year review, consideration should be given to adjusting 90844 accordingly.

A higher work value for 90844 is also supported by 80 percent of all respondents who reported that the work associated with this service has changed over the past five years. Of these, over 75 percent report that the complexity of patient problems being seen in the office and in the hospital has increased. Slightly over one-half of all respondents report that the usual site of service has shifted from the inpatient to the outpatient setting. Medicare data support this shift. In 1988, 51 percent of this service was performed in the inpatient setting and by 1994 this proportion had declined to 15 percent. Finally, a large proportion of respondents report that the work of performing this service has increased in terms of coordinating with other health professionals (67 percent); documenting services (90 percent); and communicating with third party payers (98 percent).

The vast majority (95 percent) of respondents consider the vignettes to be representative of their typical patients.

Public Comments

06-Jul-95

Code: 90844

1995 RVUs: 1.72

Recommended RVUs: 2.29

Ratio:

Long Descriptor: Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy; approximately 45 to 50 minutes

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 5,041,835 **Impact:** 2873846

Source: 7 **Year:** 93 **Public Comment Letter:** 272

Reference Services:

CMD Comment:

Societies Wishing to Survey: AACAP, ANA, APA, APA-HCPAC

Societies Wishing to Comment: AAP, NASW

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90844	22.2	6.6	12.3	63.3	51.8	0.2	0.5	6.4

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
90844	4876262	5552870	6.7

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90844	21	15.3	-2.8

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
90844	group practices	2.1
	other nonphysician prov	15
	psychiatry	55.4
	psychology	25.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90844	295	4.1	SCHIZOPHRENIC DISORDERS
	296	8.9	AFFECTIVE PSYCHOSES

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300	5.6	NEUROTIC DISORDERS
301	1	PERSONALITY DISORDERS
309	3.1	ADJUSTMENT REACTION

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90844							
AACAP		XXX	XXX	1.30	1.72	1.32	1.58
APA		XXX	XXX	1.30	1.72	1.32	1.58

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90844								
AACAP	1.72	1.72	1.22	1.09	1.00	1.00	2.29	272
APA	1.72	1.72	1.22	1.09	1.00	1.00	2.23	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
90844								
AACAP	XXX	1.30	.	.	.	50	.	11
APA	XXX	1.30	.	.	.	50	.	11

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90844									
AACAP
APA

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90844									
AACAP	.	.	.	2.29	1.72	py	n	.	0.022
APA	.	.	.	2.23	1.72	py	n	.	0.022

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90853 Global Period: _____ Current RVW: .43 Recommended RVW: .59

CPT Descriptor:

Group medical psychotherapy (other than of a multiple-family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Vignette 1

- ◆ Office group psychotherapy with eight men and women with dual diagnosis substance abuse and personality disorders.

Description of Pre-Service Work:

Preparing to see patient. Review of record of patient, including review of medication and lab studies. Consultation with collateral source from half of the patients.

Description of Intra-Service Work:

Observed mental status of each patient. Observation and interpretation of patterns of interaction among patients in group. Interpretation of effects of personality patterns and substance abuse behavior on group interactions and on reported behavior outside the group.

Description of Post-Service Work:

Dictation of records. Arrangement for next group service and for other individual services this patient requires. Communication with third party for coverage. Arrangement for follow up, including drug screening, appropriate lab studies for medication, follow up individual psychiatric and other medical services. May include coordinating and/or supervision of co-therapist. Reports to employee assistant managers, law enforcement agencies. Telephone communication with family is much greater in this type of group.

Vignette 2

- ◆ Group psychotherapy in residential treatment facility for six adolescent females. Diagnosis unspecified.

Description of Pre-Service Work:

Communicating with houseparents, nursing staff, and parents concerning the patient. Review of records and results of studies since last session. Review of chart.

Description of Intra-Service Work:

Seeing the patient. Making observations and assessing mental status within the group setting. Interpreting interactions and behavioral manifestations of illnesses present.

Description of Post-Service Work:

As opposed to usual hospital setting, writing notes and communicating with other professionals, third parties, and family is done after the session. Obtaining and reviewing results of studies. Reports and communications with other third parties, e.g. school. Documentation of services is done afterwards.

SURVEY DATA:

Specialty: Psychiatry (APA), Psychology, Nursing

Sample Size: 483¹ Response Rate (%): 13%(62) Median RVW: 1.74

25th Percentile RVW: .60 75th Percentile RVW: 2.49 Low: .25 High: 5.00

Median Pre-Service Time: 10 Median Intra-Service Time: 80 Min.

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 10 High: 120

Median Post-Service Time:

	<u>Total Time</u>
Documentation of the service provided	<u>15</u>
Arranging for further services	<u>5</u>
Reviewing results of studies	<u>4</u>
Communicating further with patient, family, and other professionals including reports	<u>10</u>
Providing written or telephone reports to Medicare or other third party payors	<u>10</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	90849	Multiple Family Group Medical Psychotherapy	.59
2)	99244	Office consultation (60 minutes)	2.23
3)	99231	Subsequent hospital care, per day (15 minutes)	.51

¹ The American Psychological Association sampled a total of 546 psychologists, of which 186 were targeted to this code.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90853	5	80	44	4	4	4
90849	10	60	26	3.5	4	3.5
99244	10	60	45	4	3	3
99231	5	15	5	3	3	2

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A value of .59 for 90853 is more appropriate than the median RVU of 1.74 indicated by the survey results. It appears that while the majority of respondents understood that the rating should be based on an individual member in the group, others rated the service based on the entire group. Thus the survey results revealed a bi-modal distribution. The reference service used by 60 percent of respondents to value this code was 90849 with a value of .59. About 10 percent of survey respondents used 99244 (RVU 2.23) and 99231 (RVU .51) as reference services. The survey respondents believe that the relationship between the codes is similar, with 90853 believed to have more intra-service time. Moreover, if we assume that all respondents who rated 90853 above 1.0 actually gave a value for the entire group (a conservative assumption) and we divided these values by the number of persons in the group (6 or 8 depending on the vignette) the new median would be .59.

A higher work value for 90853 is also supported by the two-thirds of survey respondents who report that the work associated with performing this service has increased over the past five years. Of these, almost 80 percent report that the complexity of patient problems being seen in the office and in the hospital has increased. Respondents also report that the work associated with this service has increased: 62 percent find that the work associated with coordinating with other professionals has increased; 88 percent of respondents report that the work in documenting services has increased; and 97 percent report that the work in communicating with third party payers has increased.

The majority (71 percent) of respondents consider the vignette to be representative of their typical patients.

Public Comments

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Code: 90853

1995 RVUs: 0.43

Recommended RVUs: 0.57

Ratio:

Long Descriptor: Group medical psychotherapy (other than of a multiple-family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated

Reference Set (y/n): Y Global Period: XXX Frequency: 1,691,551 Impact: 236817

Source: 7 Year: 93 Public Comment Letter: 272

Reference Services:

CMD Comment:

Societies Wishing to Survey: ANA, APA, APA-HCPAC

Societies Wishing to Comment: AACAP, AAP, ASIM, NASW

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90853	32	13.7	19.7	54.4	50.9	0.1	0.1	7.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90853	1540370	1743946	6.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90853	13.9	8.3	-2.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90853	group practices	4.8
	other nonphysician prov	22
	psychiatry	41.5
	psychology	29.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90853	290	2.1	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS
	295	7.7	SCHIZOPHRENIC DISORDERS

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296	5.2	AFFECTIVE PSYCHOSES
300	2.4	NEUROTIC DISORDERS
309	2.6	ADJUSTMENT REACTION
311	1.2	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90853							
AACAP		XXX	XXX	0.33	0.43	1.30	0.40
APA		XXX	XXX	0.33	0.43	1.30	0.40

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90853								
AACAP	0.43	0.43	1.21	1.07	1.00	1.00	0.57	272
APA	0.43	0.43	1.21	1.07	1.00	1.00	0.55	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
90853								
AACAP	XXX	0.33	t	.	.	.	.	.
APA	XXX	0.33	t	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90853									
AACAP
APA

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90853									
AACAP	.	.	.	0.57	0.43	py	n	.	.
APA	.	.	.	0.55	0.43	py	n	.	.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 90855 Global Period: _____ Current RVW: 1.81 Recommended RVW: 2.15

CPT Descriptor:

Interactive individual medical psychotherapy.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

- ♦ An 8 year old with a history of separation anxiety disorder and generalized anxiety disorder, previously seen for monthly medication management and short-term psychotherapy, presents for assistance planning for a scheduled surgical procedure. She requires fact-to-face time using play materials to enact the hospital admission and surgical procedure.

Description of Pre-Service Work:

Review the record of previous treatment and medications. Talk with the surgeon about the planned surgery, including planned procedures and prognosis. Talk with the parents about their observations of the child's response to past and planned medical/surgical interventions.

Description of Intra-Service Work:

Using play equipment, re-enactment with the child of the anticipation, surgery and recovery periods, exploring his fears, anxieties, and potential coping strategies.

Description of Post-Service Work:

Talk with the parents, nursing staff where the surgery will occur, and the surgeon or his/her office staff about their observations of the patient's vulnerabilities and ways they can modify their procedures to support the child and minimize his stress.

SURVEY DATA:Specialty: Psychiatry (APA, AACAP), Psychology, NursingSample Size: 523¹ Response Rate (%): 19%(100) Median RVW: 2.2325th Percentile RVW: 1.75 75th Percentile RVW: 2.50 Low: .92 High: 5.65Median Pre-Service Time: 10 Median Intra-Service Time: 50 Min.25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 50 Low: 25 High: 150

Median Post-Service Time:

	<u>Total Time</u>
Documentation of the service provided	<u>10</u>
Arranging for further services	<u>5</u>
Reviewing results of studies	<u>2</u>
Communicating further with patient, family, and other professionals including reports	<u>15</u>
Providing written or telephone reports to Medicare or other third party payors	<u>10</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99244	Office consultation (60 minutes)	2.23
2)	99404	Counseling and/or risk reduction interventions (60 minutes)	1.95
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	<u>Pre</u>	<u>Intra</u>	<u>Post</u>	<u>Mental</u>	<u>Technical Skill and Physical Effort</u>	<u>Psychological Stress</u>
90855	10	50	42	4	4	3
99244	8	60	25	4	4	3
99404	0	50	10	2	2	1

¹ The American Psychological Association sampled a total of 546 psychologists, of which 186 were targeted to this code.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A recommended RVU value of 2.15 is supported by the survey results and the relationship of 90855 to the reference service used to develop the RVU value. The recommended value is about 4 percent lower than the survey median. About 30 percent of the respondents used 99244 (RVU 2.23) as the reference service for 90855 and the survey results indicate that 99244 requires more time and more psychological stress than 90855. Thus, the RVU for 90855 should be less than 99244. Moreover, survey respondents consider 90855 to be of longer duration, particularly in post-service time, and of higher intensity than 90844 with a recommended RVU of 2.00. It is important to note that our reference service is an EM code that is subject to change under the five year review. To the extent that the values of any of these reference services change as part of the five year review, consideration should be given to adjusting 90855 accordingly.

A higher work value for 90855 is also supported by the 80 percent of survey respondents who reported that the work associated with this service has changed over the past five years. Two-thirds of respondents report that the complexity of patient problems being seen in the office and in the hospital has increased, which is a particularly high result given that the code is a new code. Finally, a large proportion of respondents report that the work of performing this service has increased in terms of coordinating with other health professionals (70 percent); documenting services (86 percent); and communicating with third party payers (94 percent).

The majority (68 percent) of respondents consider the vignettes to be representative of their typical patients. It is important to note that 95 percent of child psychiatrists and 80 percent of psychiatrists consider the vignette to be typical of their patients.

Public Comments

06-Jul-95

Code: 90855

1995 RVUs: 1.81

Recommended RVUs: 2.58

Ratio:

Long Descriptor: Interactive individual medical psychotherapy

Reference Set (y/n): N Global Period: XXX Frequency: 349,875 Impact: 269404

Source: 7 Year: 93 Public Comment Letter: 295

Reference Services:

CMD Comment:

Societies Wishing to Survey: AACAP, ANA, APA, APA-HCPAC

Societies Wishing to Comment: AAP, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90855	44.3	16.4	15.2	61.9	35.4	0.1	0.2	7.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90855	51889	367196	166

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90855	25.1	25.6	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90855	other nonphysician prov	2.7
	psychiatry	89.3
	psychology	5.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90855	290	3.4	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS
	293	2.3	TRANSIENT ORGANIC PSYCHOTIC CONDITIONS

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294	1	OTHER ORGANIC PSYCHOTIC CONDITIONS (CHRONIC)
295	5.3	SCHIZOPHRENIC DISORDERS
296	9	AFFECTIVE PSYCHOSES
300	1.8	NEUROTIC DISORDERS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90855							
AACAP			XXX	.	1.81	.	1.57
APA			XXX	.	1.81	.	1.57

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90855								
AACAP	1.81	1.81	.	1.15	1.00	1.00	2.40	272
APA	1.81	1.81	.	1.15	1.00	1.00	2.58	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
90855								
AACAP	XXX	.	.	.	.	.	.	.
APA	XXX	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90855									
AACAP
APA

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90855									
AACAP	.	.	.	2.40	1.81	.	.	.	.
APA	.	.	.	2.58	1.81	.	.	.	.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90862 Global Period: _____ Current RVW: .95 Recommended RVW: 1.30

CPT Descriptor:

Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Vignette 1

- ◆ 72 year old man with bipolar disorder, or lithium with familial benign tremor, comes in for treatment because his tremor has suddenly become worse.

Vignette 2

- ◆ An 8 year old boy on ritalin for Attention Deficit and Hyperactivity Disorder (ADHD) is developing tics and comes in for medication management.

Description of Pre-Service Work:

Preparing to see the patient. Review of records. Ordering laboratory services. Reviewing the results of lab tests. Communicating with neurologist concerning patient's tremor. Telephone call to wife/family.

Description of Intra-Service Work:

Mental status examination with especial assessment of mood disorder and cognitive examination. History of present illness. Review of history of taking medication. Examination of tremor, including brief neurological assessment. Regulation of medication.

Description of Post-Service Work:

Arranging for follow up visit. Arrangement for lab studies after medicine change. Communicating with neurological consultant. Documentation of services and providing reports to third party. Telephone call to wife to assure patient's adequate hydration.

SURVEY DATA:Specialty: Psychiatry (APA, AACAP), NursingSample Size: 337 Response Rate (%): 40%(136) Median RVW: 1.3025th Percentile RVW: 1.07 75th Percentile RVW: 1.76 Low: .51 High: 7.40Median Pre-Service Time: 5 Median Intra-Service Time: 25 Min.25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 30 Low: 10 High: 120

Median Post-Service Time:	<u>Total Time</u>
Documentation of the service provided	<u>5</u>
Arranging for further services	<u>5</u>
Reviewing results of studies	<u>3</u>
Communicating further with patient, family, and other professionals including reports	<u>5</u>
Providing written or telephone reports to Medicare or other third party payors	<u>5</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99243	Office consultation (40 minutes)	1.14
2)	99203	Office visit (30 minutes)	1.47
3)	99262	Follow-up inpatient consultation (20 minutes)	.75
4)	99232	Subsequent hospital care (25 minutes)	.88

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90862	5	25	23	4	4	3
99243	5	28	25	3	3	3
99203	5	30	16	3	3	2
99262	0	20	10	3	3	3
99232	0	25	10	3	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A recommended RVU of 1.3 is supported by the survey results and the relationship of 90862 to the reference services used to develop the RVU. The time and intensity involved in performing 90862 was viewed as less than 99203 (RVU 1.47), more than 99262 (RVU .75) and about the same time but greater intensity than 99243 (RVU 1.14). It is important to note that our reference services are EM codes that are subject to review. To the extent that the values of either of these reference services changes as part of the five year review, consideration should be given to altering the psychiatric values that were derived from those reference values.

A higher work value for 90862 is also supported by the 81 percent of respondents who reported that the work associated with this service has changed over the past five years. Of these, 80 percent of all respondents report that the complexity of patient problems being seen in the office has increased, while 76 percent of respondents report that the complexity of patient problems seen in the hospital has increased. The majority of respondents report that the work of performing this service has increased in terms of coordinating with other health professionals (75 percent); documenting services (90 percent); and communicating with third party payers (96 percent).

The work involved in 90862 has changed significantly since the original work value was developed. First, simple medication follow-up is done by primary care physicians. Psychiatrists' services are now sought, as the vignette indicates, when there are some complications which call for specialized psychiatric services. Second, the patients, especially in managed care settings, are seen for psychotherapy by non-physician practitioners. When there is indication for pharmacologic management, the patient is referred to the physician whose service under this code resembles, but is not identical to, 99243, consultation. The psychiatrist performing 90862 must do an evaluation and examination to grasp changes in clinical state since the previous examination, then utilize medical decision-making to deal with possible alterations of psychiatric medicine while weighing other medical conditions and other medications. Patients are frequently on several medications for other medical conditions requiring careful management.

For example, in the first vignette, pre-service calls had to be made to the neurologist who follows his tremor and to the primary care physician who medicates his hypertension. The degree of hypomanic behavior has to be assessed and a focused neurologic examination had to be done to differentiate the benign tumor from lithium tremor and from senile or extrapyramidal tremor or tremor of other etiology before medication management was possible.

The vast majority (92 percent) of respondents consider the vignettes to be representative of their typical patients.

CMD Comments

06-Jul-95

Code: 90862

1995 RVUs: 0.95

Recommended RVUs: 0.55

Ratio: -0.42

Long Descriptor: Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

Reference Set (y/n): Y Global Period: XXX Frequency: 2,390,131 Impact: -956052.4

Source: 7 Year: 93 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
90862			
	99213 OFFICE/OUTPATIENT VISIT, EST	0.55	XXX

CMD Comment:

90862 is comparable to 99213. Standard of practice for this service is for 15 minutes of face to face time with a low level of stress and intensity. This code is abused because of its relatively high payment and low work requirement.

Societies Wishing to Survey: AACAP, AAP, ANA, APA

Societies Wishing to Comment: AAPM, APA-HCPAC, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90862	25.5	7.8	15.9	54.6	54.4	0.1	0.4	9.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90862	1878480	2602878	17.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90862	23.1	19.6	-1.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90862		
	general/family practice	2.3
	group practices	5.7
	other nonphysician prov	3
	psychiatry	87.2

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
90862		
290	2.2	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS
295	8.3	SCHIZOPHRENIC DISORDERS
296	8.1	AFFECTIVE PSYCHOSES
300	2	NEUROTIC DISORDERS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90862							
APA				0.82			
CMD		XXX	XXX	0.82	0.95	1.16	0.81

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
90862								
APA							1.40	295
CMD	0.95	0.95	0.99	1.17	1.00	1.00	0.55	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
90862								
APA	XXX	0.82				28		9
CMD	XXX	0.82				28		9

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
90862									
APA									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90862									
APA				1.40	0.95	py	n		0.023
CMD				0.55	0.95	py	n		0.023

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90887 Global Period: _____ Current RVW: 1.48 Recommended RVW: 2.00

CPT Descriptor:

Interpretation or examination of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The father and stepmother of a 7 year old girl request an explanation of findings on their daughter whom the biological mother brought for evaluation. The biological parents share custody. The patient has been distractible, unable to learn to read, and has no friends. The father is financially responsible for medical treatment and wants to know why medication AND behavioral management are recommended.

Description of Pre-Service Work:

Review of the history, findings, and laboratory to present to the father and stepmother.

Description of Intra-Service Work:

Presentation of the findings and treatment recommendation, as well as review of the custody arrangement, the financial obligation of the father, and the rationale for the combination of medication and behavioral management.

Description of Post-Service Work:

Contact the biological mother to inform her of the process; perhaps contact the attorney.

SURVEY DATA:Specialty: Psychiatry (APA, AACAP), Psychology, NursingSample Size: 523¹ Response Rate (%): 23%(122) Median RVW: 2.025th Percentile RVW: 1.71 75th Percentile RVW: 2.25 Low: .5 High: 7.25Median Pre-Service Time: 10 Median Intra-Service Time: 50 Min25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 60 Low: 15 High: 100

Median Post-Service Time:

Total TimeDocumentation of the service provided 8Arranging for further services 3Reviewing results of studies 2Communicating further with patient, family, and
other professionals including reports 10Providing written or telephone reports to
Medicare or other third party payors 5**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99404	Counseling and/or risk reduction interventions (60 minutes)	1.95
2)	99244	Office consultation (60 minutes)	2.23
3)	99386	Initial evaluation of healthy individual	1.88
4)	99204	Office visit (45 minutes)	1.71

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90887	10	50	28	4	4	3
99404	5	60	25	3	3	3
99244	5	60	37	4	4	3
99386	10	45	37	3	3	3
99204	10	45	38	3	3	3

¹ The American Psychological Association sampled a total of 546 psychologists, of which 186 were targeted to this code.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A recommended RVU value of 2.00 is supported by the survey results. This service was viewed as identical to 99404 (1.95) in terms of time but of higher intensity, thus 90887 should have a higher value than 99404. Similarly, this service is considered to be more time and higher intensity than both 99204 (RVU 1.71) and 99386 (1.88), although it is viewed as less time and intensity than 99244 (RVU 2.23). Given the relationship of 90887 to the reference services, a value of 2.00 is appropriate.

A higher work value for 90887 is also supported by the 64 percent of respondents who reported that the work associated with this service has changed over the past five years. Of these, three-quarters of respondents report that the complexity of patient problems being seen in the office has increased, while 61 percent report that the complexity of patient problems being seen in the hospital has increased. An analysis of Medicare data suggest that the usual site of service has shifted from the inpatient to outpatient setting. In 1988 51 percent of services for this code were performed in the inpatient setting. By 1994 this proportion declined to 25 percent. Finally, a large proportion of respondents report that the work of performing this service has increased in terms of coordinating with other health professionals (67 percent); documenting services (84 percent); and communicating with third party payers (93 percent).

The vast majority (81 percent) of respondents consider the vignettes to be representative of their typical patients.

CMD Comments

06-Jul-95

Code: 90887

1995 RVUs: 1.48

Recommended RVUs: 0.94

Ratio: -0.36

Long Descriptor: Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient

Reference Set (y/n): N Global Period: XXX Frequency: 45,103 Impact: -24355.62

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
90887			
	99214 OFFICE/OUTPATIENT VISIT, EST	0.94	XXX
	99215 OFFICE/OUTPATIENT VISIT, EST	1.51	XXX

CMD Comment:

CPT 99214, average 25 minutes, if spent entirely in counseling a family member or patient, would be 0.94. The intensity and time spent and interpreting to family regarding psychiatric problems is no different.

Societies Wishing to Survey: AACAP, AAP, AAPM, ANA, APA, APA-HCPAC

Societies Wishing to Comment: ACEP, ASIM, NASW, RPA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90887	50.7	16.8	16.1	60.5	30.7	0.2	0.9	3.7

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
90887	16014	44266	66.3

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90887	32.4	24.8	-3.8

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
90887		
	general/family practice	2.3
	group practices	4.9
	internal medicine	4
	other nonphysician prov	5.5
	psychiatry	63.4
	psychology	17.5

CMD Comments

06-Jul-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90887			
	290	4.5	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS
	293	1.8	TRANSIENT ORGANIC PSYCHOTIC CONDITIONS
	294	1.2	OTHER ORGANIC PSYCHOTIC CONDITIONS (CHRONIC)
	295	5.4	SCHIZOPHRENIC DISORDERS
	296	5.3	AFFECTIVE PSYCHOSES
	300	1.7	NEUROTIC DISORDERS
	301	1.9	PERSONALITY DISORDERS
	309	2.4	ADJUSTMENT REACTION

Harvard Data:

	Comm	Modif	Packdv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90887								
	APA		XXX	XXX	1.49	1.48	0.99	1.48
	CMD		XXX	XXX	1.49	1.48	0.99	1.48

Harvard Data:

	Comm	Mawk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
90887									
	APA	1.48	1.48	0.99	1.00	1.00	1.00	2.56	295
	CMD	1.48	1.48	0.99	1.00	1.00	1.00	0.94	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
90887									
	APA	XXX	1.49	t	.	.	65	t	.
	CMD	XXX	1.49	t	.	.	65	t	.

Harvard Data:

	Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90887										
	APA	.	.	.	.	.	.	.	.	.
	CMD	.	.	.	.	.	.	.	.	.

Harvard Data:

CMD Comments

06-Jul-95

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfawk95	Sp	Phase	Twput	lwput
90887									
APA				2.56	1.48	py	n	0.023	
CMD				0.94	1.48	py	n	0.023	

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90845 Global Period: _____ Current RVW: 1.78 Recommended RVW: 1.78

CPT Descriptor:

Medical psychoanalysis.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Vignette 1

- ◆ A 37-year-old man with dysthymia and narcissistic personality disorder manifested by entitlement, inability to be intimate, and extreme variability of self esteem is seen in the second year of psychoanalysis, just prior to going on a business trip. Argumentative and easily offended, he accuses the analyst of being insensitive and detached, and angrily rejects any effort to explore the basis of his mood or behavior.

Vignette 2

- ◆ A 17-year-old girl with generalized anxiety and an eating disorder in the sixth month of psychoanalysis with a female analyst reveals for the first time that she experiences her father's behavior as seductive and her mother as remote and hostile, unable to help her manage her feelings. She desperately wants to be held and comforted by the analyst and worries that she won't be able to leave when the session is over.

Description of Pre-Service Work:

Reviewing notes, arranging clinical setting, telephone work related to appointments. 3-10 minutes.

Description of Intra-Service Work:

Establishment and maintenance of working relationship. Intense observation, listening, and analysis of patient behavior, emotion, and verbal productions, as well as assessing contributory general medical problems. Expert self-observation for reactions to patient and assessment of relevance to understanding of patient. Formulation of working hypotheses regarding patient's mental processes and experiences. Development of responses to patient to 1) elicit further information, 2) facilitate further exploration and awareness by patient, 3) aid patient in clarifying self-observations, 4) assist patient in understanding and modulating regression during this session and as part of the ongoing treatment, 5) facilitate patient's integrated, in-depth understanding (insight), and 6) assist patient in working through barriers (resistance) to adaptive change of mental status and behavior. Ongoing monitoring and reassessment of need for psychotropic medications and/or ongoing assessment of impact of medication on the patient and the treatment process. 45-50 minutes.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90845	5	45	11	4	4	4
99243	5	45	10	3	4	2
99244	5	60	25	4.5	4	3.5
99404	0	50	10	2	2	1
99204	5	50	40	2	2	1

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The survey results support maintaining the current RVU value for 90845. The median RVU is almost the same as the current value and almost two thirds of survey respondents report that the work associated with this service has remained the same over the past five years. In addition, Medicare data does not suggest a shift in the site of care or in the distribution of providers performing this service. Survey results indicate that 85 percent of respondents consider the vignette typical of their patients. It is important to note that our reference services are EM codes that are subject to change under the five-year review. To the extent that the values of any of these reference services change as part of the five-year review, consideration should be given to adjusting 90845 accordingly.

Public Comments

06-Jul-95

Code: 90845

1995 RVUs: 1.78

Recommended RVUs: 2.34

Ratio:

Long Descriptor: Medical psychoanalysis

Reference Set (y/n): N

Global Period: XXX

Frequency: 18,791

Impact: 10523

Source: 7

Year: 93

Public Comment Letter: 295

Reference Services:

CMD Comment:

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Societies Wishing to Survey: APA, APA-HCPAC

Societies Wishing to Comment: AACAP, AAP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90845	33.7	3.6	12.1	74	27.8	0	0.3	4.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90845	12374	20234	27.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90845	29.5	18.8	-5.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90845	other nonphysician prov	8.7
	psychiatry	86
	psychology	3.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90845	295	3.3	SCHIZOPHRENIC DISORDERS
	296	12.3	AFFECTIVE PSYCHOSES
	300	3.9	NEUROTIC DISORDERS
	301	1.2	PERSONALITY DISORDERS

Public Comments

06-Jul-95

309	2.4	ADJUSTMENT REACTION
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90845							
AACAP		XXX	XXX	1.35	1.78	1.32	1.35
APA		XXX	XXX	1.35	1.78	1.32	1.35

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90845								
AACAP	1.78	1.78	1.00	1.32	1.00	1.00	2.37	272
APA	1.78	1.78	1.00	1.32	1.00	1.00	2.34	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
90845								
AACAP	XXX	1.35				50		8
APA	XXX	1.35				50		8

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90845									
AACAP									
APA									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90845									
AACAP				2.37	1.78	py	n		0.024
APA				2.34	1.78	py	n		0.024

Public Comments

06-Jul-95

Code: 90846

1995 RVUs: 1.82

Recommended RVUs: 2.90

Ratio:

Long Descriptor: Family medical psychotherapy (without the patient present)

Reference Set (y/n): N

Global Period: XXX

Frequency: 14,079

Impact: 15205

Source: 7

Year: 93

Public Comment Letter: 295

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ANA, APA-HCPAC

Societies Wishing to Comment: AACAP, AAP, APA, ASIM, NASW

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90846	50.3	19.9	8.3	61.6	25.6	0	0.3	9.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90846	5260	14602	66.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90846	27.2	20.4	-3.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90846	group practices	6.4
	other nonphysician prov	31.6
	psychiatry	45
	psychology	14.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90846	290	3	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS
	295	6.8	SCHIZOPHRENIC DISORDERS

Public Comments

06-Jul-95

296	5.8	AFFECTIVE PSYCHOSES
300	1.2	NEUROTIC DISORDERS
301	2.6	PERSONALITY DISORDERS
309	3.8	ADJUSTMENT REACTION
311	1.6	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED
331	1.3	OTHER CEREBRAL DEGENERATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90846							
AACAP		XXX	XXX	1.69	1.82	1.08	1.67
APA		XXX	XXX	1.69	1.82	1.08	1.67

Harvard Data:

Comm	Mawk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90846								
AACAP	1.82	1.82	0.99	1.09	1.00	1.00	2.42	272
APA	1.82	1.82	0.99	1.09	1.00	1.00	2.90	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
90846								
AACAP	XXX	1.69				50		23
APA	XXX	1.69				50		23

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90846									
AACAP									
APA									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
90846									
AACAP				2.42	1.82	py	n		0.027
APA				2.90	1.82	py	n		0.027

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90847 Global Period: _____ Current RVW: 2.19 Recommended RVW: 2.10

CPT Descriptor:

Family medical psychotherapy (conjoint psychotherapy) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Vignette 1

- ◆ Conjoint psychotherapy in the office, eighth weekly session, for a married couple in their early 40s, for marital problems. The woman is having moderate depression with vegetative signs and is gradually improving with antidepressant medication.

Vignette 2

- ◆ Parents require therapy due to their disagreement about how to handle a 14 year old gifted child who is failing in school and violating curfew.

Description of Pre-Service Work:

Preparing to see patient. Review of records. Occasionally communicating with other providers who may be managing the woman's depression.

Description of Intra-Service Work:

Observation and interpretation of interactive patterns of communication and behavior of this couple with each other. Interpreting relation of these patterns to past patterns of behavior. Mental status examination of depressed wife with special emphasis on changes in vegetative signs since last examination. Decision making concerning course of depression and further course of treatment. Discussion of side effects of medication and whatever physical examination is appropriate to medicine.

Description of Post-Service Work:

Arranging for next service, including prorated time to communicate with third party for coverage. Dictating record.

SURVEY DATA:Specialty: Psychiatry (APA), NursingSample Size: 297 Response Rate (%): 28%(83) Median RVW: 2.0025th Percentile RVW: 1.5 75th Percentile RVW: 2.25 Low: .59 High: 3.9Median Pre-Service Time: 5 Median Intra-Service Time: 50 Min.25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 60 Low: 30 High: 120

Median Post-Service Time:

Total TimeDocumentation of the service provided 5Arranging for further services 1Reviewing results of studies 0Communicating further with patient, family, and
other professionals including reports 5Providing written or telephone reports to
Medicare or other third party payors 10**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99244	Office consultation	2.23
2)	99243	Office consultation	1.47
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	<u>Pre</u>	<u>Intra</u>	<u>Post</u>	<u>Mental</u>	<u>Technical Skill and Physical Effort</u>	<u>Psychological Stress</u>
90847	5	50	21	3	3	3
99244	5	60	25	4	4	3
99243	5	45	20	3	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A recommended RVU value of 2.10 is 4 percent lower than the current value and reflects the survey median for psychiatrists. Although the consolidated median was 2.00, psychiatrists represent three-quarters of all respondents and rated the service a 2.11 RVU. Moreover, psychiatrists rated this service higher in intensity than 90844 which received a work RVU of 2.00. It is important to note that our reference services are EM codes that are subject to change under the five-year review. To the extent that the values of any of these reference services change as part of the five-year review, consideration should be given to adjusting 90847 accordingly.

The vast majority (90 percent) of respondents consider the vignettes to be representative of their typical patients.

Public Comments

06-Jul-95

Code: 90847

1995 RVUs: 2.19

Recommended RVUs: 2.91

Ratio:

Long Descriptor: Family medical psychotherapy (conjoint psychotherapy) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated

Reference Set (y/n): N Global Period: XXX Frequency: 77,897 Impact: 56086

Source: 7 Year: 93 Public Comment Letter: 272

Reference Services:

CMD Comment:

Societies Wishing to Survey: ANA, APA, APA-HCPAC

Societies Wishing to Comment: AACAP, AAP, ASIM, NASW

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90847	33.5	10.5	8.3	53.6	34.7	1.6	0.5	9.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90847	44476	80138	34.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90847	22.9	16.7	-3.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90847	group practices	4.1
	other nonphysician prov	14.3
	psychiatry	59.9
	psychology	18.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90847	290	2.4	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS

Public Comments

06-Jul-95

293	1.1	TRANSIENT ORGANIC PSYCHOTIC CONDITIONS
295	2.3	SCHIZOPHRENIC DISORDERS
296	9.2	AFFECTIVE PSYCHOSES
300	5.7	NEUROTIC DISORDERS
301	1.3	PERSONALITY DISORDERS
309	3.4	ADJUSTMENT REACTION

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90847							
AACAP		XXX	XXX	1.88	2.19	1.16	2.01
APA		XXX	XXX	1.88	2.19	1.16	2.01

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90847								
AACAP	2.19	2.19	1.07	1.09	1.00	1.00	2.91	272
APA	2.19	2.19	1.07	1.09	1.00	1.00	3.21	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
90847								
AACAP	XXX	1.88	.	.	.	50	.	26
APA	XXX	1.88	.	.	.	50	.	26

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
90847									
AACAP
APA

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90847									
AACAP	.	.	.	2.91	2.19	py	n	.	0.026
APA	.	.	.	3.21	2.19	py	n	.	0.026

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90853 Global Period: _____ Current RVW: .43 Recommended RVW: .59

CPT Descriptor:

Group medical psychotherapy (other than of a multiple-family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Vignette 1

- ◆ Office group psychotherapy with eight men and women with dual diagnosis substance abuse and personality disorders.

Description of Pre-Service Work:

Preparing to see patient. Review of record of patient, including review of medication and lab studies. Consultation with collateral source from half of the patients.

Description of Intra-Service Work:

Observed mental status of each patient. Observation and interpretation of patterns of interaction among patients in group. Interpretation of effects of personality patterns and substance abuse behavior on group interactions and on reported behavior outside the group.

Description of Post-Service Work:

Dictation of records. Arrangement for next group service and for other individual services this patient requires. Communication with third party for coverage. Arrangement for follow up, including drug screening, appropriate lab studies for medication, follow up individual psychiatric and other medical services. May include coordinating and/or supervision of co-therapist. Reports to employee assistant managers, law enforcement agencies. Telephone communication with family is much greater in this type of group.

Vignette 2

- ◆ Group psychotherapy in residential treatment facility for six adolescent females. Diagnosis unspecified.

Description of Pre-Service Work:

Communicating with houseparents, nursing staff, and parents concerning the patient. Review of records and results of studies since last session. Review of chart.

Description of Intra-Service Work:

Seeing the patient. Making observations and assessing mental status within the group setting. Interpreting interactions and behavioral manifestations of illnesses present.

Description of Post-Service Work:

As opposed to usual hospital setting, writing notes and communicating with other professionals, third parties, and family is done after the session. Obtaining and reviewing results of studies. Reports and communications with other third parties, e.g. school. Documentation of services is done afterwards.

SURVEY DATA:

Specialty: Psychiatry (APA), Psychology, Nursing

Sample Size: 483¹ Response Rate (%): 13%(62) Median RVW: 1.74

25th Percentile RVW: .60 75th Percentile RVW: 2.49 Low: .25 High: 5.00

Median Pre-Service Time: 10 Median Intra-Service Time: 80 Min.

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 10 High: 120

Median Post-Service Time:	<u>Total Time</u>
Documentation of the service provided	<u>15</u>
Arranging for further services	<u>5</u>
Reviewing results of studies	<u>4</u>
Communicating further with patient, family, and other professionals including reports	<u>10</u>
Providing written or telephone reports to Medicare or other third party payors	<u>10</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	90849	Multiple Family Group Medical Psychotherapy	.59
2)	99244	Office consultation (60 minutes)	2.23
3)	99231	Subsequent hospital care, per day (15 minutes)	.51

¹ The American Psychological Association sampled a total of 546 psychologists, of which 186 were targeted to this code.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90853	5	80	44	4	4	4
90849	10	60	26	3.5	4	3.5
99244	10	60	45	4	3	3
99231	5	15	5	3	3	2

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A value of .59 for 90853 is more appropriate than the median RVU of 1.74 indicated by the survey results. It appears that while the majority of respondents understood that the rating should be based on an individual member in the group, others rated the service based on the entire group. Thus the survey results revealed a bi-modal distribution. The reference service used by 60 percent of respondents to value this code was 90849 with a value of .59. About 10 percent of survey respondents used 99244 (RVU 2.23) and 99231 (RVU .51) as reference services. The survey respondents believe that the relationship between the codes is similar, with 90853 believed to have more intra-service time. Moreover, if we assume that all respondents who rated 90853 above 1.0 actually gave a value for the entire group (a conservative assumption) and we divided these values by the number of persons in the group (6 or 8 depending on the vignette) the new median would be .59.

A higher work value for 90853 is also supported by the two-thirds of survey respondents who report that the work associated with performing this service has increased over the past five years. Of these, almost 80 percent report that the complexity of patient problems being seen in the office and in the hospital has increased. Respondents also report that the work associated with this service has increased: 62 percent find that the work associated with coordinating with other professionals has increased; 88 percent of respondents report that the work in documenting services has increased; and 97 percent report that the work in communicating with third party payers has increased.

The majority (71 percent) of respondents consider the vignette to be representative of their typical patients.

Public Comments

06-Jul-95

Code: 90853

1995 RVUs: 0.43

Recommended RVUs: 0.57

Ratio:

Long Descriptor: Group medical psychotherapy (other than of a multiple-family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 1,691,551 **Impact:** 236817

Source: 7 **Year:** 93 **Public Comment Letter:** 272

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ANA, APA, APA-HCPAC

Societies Wishing to Comment: AACAP, AAP, ASIM, NASW

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90853	32	13.7	19.7	54.4	50.9	0.1	0.1	7.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90853	1540370	1743946	6.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90853	13.9	8.3	-2.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90853	group practices	4.8
	other nonphysician prov	22
	psychiatry	41.5
	psychology	29.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90853	290	2.1	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS
	295	7.7	SCHIZOPHRENIC DISORDERS

Public Comments

06-Jul-95

296	5.2	AFFECTIVE PSYCHOSES
300	2.4	NEUROTIC DISORDERS
309	2.6	ADJUSTMENT REACTION
311	1.2	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90853							
AACAP		XXX	XXX	0.33	0.43	1.30	0.40
APA		XXX	XXX	0.33	0.43	1.30	0.40

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90853								
AACAP	0.43	0.43	1.21	1.07	1.00	1.00	0.57	272
APA	0.43	0.43	1.21	1.07	1.00	1.00	0.55	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
90853								
AACAP	XXX	0.33	t	.	.	.	.	.
APA	XXX	0.33	t	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90853									
AACAP
APA

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
90853									
AACAP	.	.	.	0.57	0.43	py	n	.	.
APA	.	.	.	0.55	0.43	py	n	.	.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90855 Global Period: _____ Current RVW: 1.81 Recommended RVW: 2.15

CPT Descriptor:

Interactive individual medical psychotherapy.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

- ◆ An 8 year old with a history of separation anxiety disorder and generalized anxiety disorder, previously seen for monthly medication management and short-term psychotherapy, presents for assistance planning for a scheduled surgical procedure. She requires fact-to-face time using play materials to enact the hospital admission and surgical procedure.

Description of Pre-Service Work:

Review the record of previous treatment and medications. Talk with the surgeon about the planned surgery, including planned procedures and prognosis. Talk with the parents about their observations of the child's response to past and planned medical/surgical interventions.

Description of Intra-Service Work:

Using play equipment, re-enactment with the child of the anticipation, surgery and recovery periods, exploring his fears, anxieties, and potential coping strategies.

Description of Post-Service Work:

Talk with the parents, nursing staff where the surgery will occur, and the surgeon or his/her office staff about their observations of the patient's vulnerabilities and ways they can modify their procedures to support the child and minimize his stress.

SURVEY DATA:Specialty: Psychiatry (APA, AACAP), Psychology, NursingSample Size: 523¹ Response Rate (%): 19%(100) Median RVW: 2.2325th Percentile RVW: 1.75 75th Percentile RVW: 2.50 Low: .92 High: 5.65Median Pre-Service Time: 10 Median Intra-Service Time: 50 Min.25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 50 Low: 25 High: 150Median Post-Service Time: Total TimeDocumentation of the service provided 10Arranging for further services 5Reviewing results of studies 2Communicating further with patient, family, and
other professionals including reports 15Providing written or telephone reports to
Medicare or other third party payors 10**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99244	Office consultation (60 minutes)	2.23
2)	99404	Counseling and/or risk reduction interventions (60 minutes)	1.95
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	<u>Pre</u>	<u>Intra</u>	<u>Post</u>	<u>Mental</u>	<u>Technical Skill and Physical Effort</u>	<u>Psychological Stress</u>
90855	10	50	42	4	4	3
99244	8	60	25	4	4	3
99404	0	50	10	2	2	1

¹ The American Psychological Association sampled a total of 546 psychologists, of which 186 were targeted to this code.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A recommended RVU value of 2.15 is supported by the survey results and the relationship of 90855 to the reference service used to develop the RVU value. The recommended value is about 4 percent lower than the survey median. About 30 percent of the respondents used 99244 (RVU 2.23) as the reference service for 90855 and the survey results indicate that 99244 requires more time and more psychological stress than 90855. Thus, the RVU for 90855 should be less than 99744. Moreover, survey respondents consider 90855 to be of longer duration, particularly in post-service time, and of higher intensity than 90844 with a recommended RVU of 2.00. It is important to note that our reference service is an EM code that is subject to change under the five year review. To the extent that the values of any of these reference services change as part of the five year review, consideration should be given to adjusting 90855 accordingly.

A higher work value for 90855 is also supported by the 80 percent of survey respondents who reported that the work associated with this service has changed over the past five years. Two-thirds of respondents report that the complexity of patient problems being seen in the office and in the hospital has increased, which is a particularly high result given that the code is a new code. Finally, a large proportion of respondents report that the work of performing this service has increased in terms of coordinating with other health professionals (70 percent); documenting services (86 percent); and communicating with third party payers (94 percent).

The majority (68 percent) of respondents consider the vignettes to be representative of their typical patients. It is important to note that 95 percent of child psychiatrists and 80 percent of psychiatrists consider the vignette to be typical of their patients.

Public Comments

06-Jul-95

Code: 90855

1995 RVUs: 1.81

Recommended RVUs: 2.58

Ratio:

Long Descriptor: Interactive individual medical psychotherapy

Reference Set (y/n): N Global Period: XXX Frequency: 349,875 Impact: 269404

Source: 7 Year: 93 Public Comment Letter: 295

Reference Services:

CMD Comment:

Societies Wishing to Survey: AACAP, ANA, APA, APA-HCPAC

Societies Wishing to Comment: AAP, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90855	44.3	16.4	15.2	61.9	35.4	0.1	0.2	7.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90855	51889	367196	166

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90855	25.1	25.6	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90855	other nonphysician prov	2.7
	psychiatry	89.3
	psychology	5.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90855	290	3.4	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS
	293	2.3	TRANSIENT ORGANIC PSYCHOTIC CONDITIONS

Public Comments

06-Jul-95

294	1	OTHER ORGANIC PSYCHOTIC CONDITIONS (CHRONIC)
295	5.3	SCHIZOPHRENIC DISORDERS
296	9	AFFECTIVE PSYCHOSES
300	1.8	NEUROTIC DISORDERS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90855							
AACAP			XXX	.	1.81	.	1.57
APA			XXX	.	1.81	.	1.57

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90855								
AACAP	1.81	1.81	.	1.15	1.00	1.00	2.40	272
APA	1.81	1.81	.	1.15	1.00	1.00	2.58	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
90855								
AACAP	XXX	.	.	.	.	.	.	.
APA	XXX	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuis	Offvis
90855									
AACAP
APA

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90855									
AACAP	.	.	.	2.40	1.81	.	.	.	.
APA	.	.	.	2.58	1.81	.	.	.	.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90857 Global Period: _____ Current RVW: .43 Recommended RVW: .59

CPT Descriptor:

Interactive group medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Pre-schoolers develop sleep problems, decreased appetite, and increased irritability after the sudden drowning death of a peer. They meet with a therapist and use play (interactive) techniques to work through the loss.

Description of Pre-Service Work:

Preparing to see patient. Review of record of patient. Consultation with collateral source from half of the patients.

Description of Intra-Service Work:

Seeing the patient. Making observations and assessing mental status within the group setting. Interpreting interactions and behavioral manifestations of illnesses present.

Description of Post-Service Work:

Dictation of records. Arrangement for next group service and for other individual services this patient requires. Communication with third party for coverage. Arrangement for follow up, follow up individual psychiatric and other medical services. May include coordinating and/or supervision of co-therapist. Reports to school. Telephone communication with family is much greater in this type of group.

SURVEY DATA:Specialty: Psychiatry (APA), Psychology, NursingSample Size: 483¹ Response Rate (%): 7%(33) Median RVW: 2.0025th Percentile RVW: 1.2 75th Percentile RVW: 2.23 Low: .25 High: 4.00Median Pre-Service Time: 15 Median Intra-Service Time: 50 Min.25th Percentile Intra-Svc Time: 40 75th Percentile Intra-Svc Time: 60 Low: 16 High: 90

Median Post-Service Time:

	<u>Total Time</u>
Documentation of the service provided	<u>12.5</u>
Arranging for further services	<u>10</u>
Reviewing results of studies	<u>0</u>
Communicating further with patient, family, and other professionals including reports	<u>20</u>
Providing written or telephone reports to Medicare or other third party payors	<u>15</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	90849	Multiple Family Group Medical Psychotherapy	.59
2)	99244	Office consultation (60 minutes)	2.23
3)			

¹ The American Psychological Association sampled a total of 546 psychologists, of which 186 were targeted to this code.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90857	15	50	57.5	4	4	4
90849	10	60	26	3.5	4	3.5
99244	10	60	45	4	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A value of .59 for 90857 is more appropriate than the median RVU of 2.00 indicated by the survey results. It appears that while the majority of respondents understood that the rating should be based on an individual member in the group, others rated the service based on the entire group. Thus the survey results revealed a bi-modal distribution. A value of .59 for 90857 is more appropriate in order to preserve the current relationship between 90853 and 90857.

A higher work value for 90853 is also supported by the majority of respondents who report that work has increased over the past five years. One-half find that the work associated with coordinating with other professionals has increased; three-quarters of respondents report that the work in documenting services has increased; and 86 percent report that the work in communicating with third party payers has increased.

Less than half (40 percent) of respondents consider the vignette to be representative of their typical patients. However, three-quarters of psychiatrists consider the vignette to be typical. This result may have occurred because the vignette was prepared by the psychiatrists.

Public Comments

06-Jul-95

Code: 90857

1995 RVUs: 0.43

Recommended RVUs: 0.57

Ratio:

Long Descriptor: Interactive group medical psychotherapy

Reference Set (y/n): N

Global Period: XXX

Frequency: 75,213

Impact: 10530

Source: 7

Year: 93

Public Comment Letter: 272

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAP, ANA, APA, APA-HCPAC

Societies Wishing to Comment: AACAP, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90857	27.7	7.6	13.5	43.9	68.2	0	0.3	6.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90857	21567	74232	85.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90857	14.8	2.7	-6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90857	general/family practice	8.3
	group practices	11.1
	other nonphysician prov	15
	psychiatry	33.6
	psychology	30.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90857	290	1.8	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS

Public Comments

06-Jul-95

295	10.6	SCHIZOPHRENIC DISORDERS
296	4	AFFECTIVE PSYCHOSES
298	3.4	OTHER NONORGANIC PSYCHOSES
303	1.1	ALCOHOL DEPENDENCE SYNDROME
V70	1	GENERAL MEDICAL EXAMINATION

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90857							
AACAP			XXX	.	0.43	.	0.40
APA			XXX	.	0.43	.	0.40

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90857								
AACAP	0.43	0.43	.	1.07	1.00	1.00	0.57	272
APA	0.43	0.43	.	1.07	1.00	1.00	0.65	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
90857								
AACAP	XXX	.	.	.	.	.	.	.
APA	XXX	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90857									
AACAP
APA

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90857									
AACAP	.	.	.	0.57	0.43	.	.	.	.
APA	.	.	.	0.65	0.43	.	.	.	.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90862 Global Period: _____ Current RVW: .95 Recommended RVW: 1.30

CPT Descriptor:

Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Vignette 1

- ◆ 72 year old man with bipolar disorder, on lithium with familial benign tremor, comes in for treatment because his tremor has suddenly become worse.

Vignette 2

- ◆ An 8 year old boy on ritalin for Attention Deficit and Hyperactivity Disorder (ADHD) is developing tics and comes in for medication management.

Description of Pre-Service Work:

Preparing to see the patient. Review of records. Ordering laboratory services. Reviewing the results of lab tests. Communicating with neurologist concerning patient's tremor. Telephone call to wife/family.

Description of Intra-Service Work:

Mental status examination with especial assessment of mood disorder and cognitive examination. History of present illness. Review of history of taking medication. Examination of tremor, including brief neurological assessment. Regulation of medication.

Description of Post-Service Work:

Arranging for follow up visit. Arrangement for lab studies after medicine change. Communicating with neurological consultant. Documentation of services and providing reports to third party. Telephone call to wife to assure patient's adequate hydration.

SURVEY DATA:Specialty: Psychiatry (APA, AACAP), NursingSample Size: 337 Response Rate (%): 40%(136) Median RVW: 1.3025th Percentile RVW: 1.07 75th Percentile RVW: 1.76 Low: .51 High: 7.40Median Pre-Service Time: 5 Median Intra-Service Time: 25 Min.25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 30 Low: 10 High: 120Median Post-Service Time: Total TimeDocumentation of the service provided 5Arranging for further services 5Reviewing results of studies 3Communicating further with patient, family, and
other professionals including reports 5Providing written or telephone reports to
Medicare or other third party payors 5**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99243	Office consultation (40 minutes)	1.14
2)	99203	Office visit (30 minutes)	1.47
3)	99262	Follow-up inpatient consultation (20 minutes)	.75
4)	99232	Subsequent hospital care (25 minutes)	.88

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	<u>Pre</u>	<u>Intra</u>	<u>Post</u>	<u>Mental</u>	<u>Technical Skill and Physical Effort</u>	<u>Psychological Stress</u>
90862	5	25	23	4	4	3
99243	5	28	25	3	3	3
99203	5	30	16	3	3	2
99262	0	20	10	3	3	3
99232	0	25	10	3	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A recommended RVU of 1.3 is supported by the survey results and the relationship of 90862 to the reference services used to develop the RVU. The time and intensity involved in performing 90862 was viewed as less than 99203 (RVU 1.47), more than 99262 (RVU .75) and about the same time but greater intensity than 99243 (RVU 1.14). It is important to note that our reference services are EM codes that are subject to review. To the extent that the values of either of these reference services changes as part of the five year review, consideration should be given to altering the psychiatric values that were derived from those reference values.

A higher work value for 90862 is also supported by the 81 percent of respondents who reported that the work associated with this service has changed over the past five years. Of these, 80 percent of all respondents report that the complexity of patient problems being seen in the office has increased, while 76 percent of respondents report that the complexity of patient problems seen in the hospital has increased. The majority of respondents report that the work of performing this service has increased in terms of coordinating with other health professionals (75 percent); documenting services (90 percent); and communicating with third party payers (96 percent).

The work involved in 90862 has changed significantly since the original work value was developed. First, simple medication follow-up is done by primary care physicians. Psychiatrists' services are now sought, as the vignette indicates, when there are some complications which call for specialized psychiatric services. Second, the patients, especially in managed care settings, are seen for psychotherapy by non-physician practitioners. When there is indication for pharmacologic management, the patient is referred to the physician whose service under this code resembles, but is not identical to, 99243, consultation. The psychiatrist performing 90862 must do an evaluation and examination to grasp changes in clinical state since the previous examination, then utilize medical decision-making to deal with possible alterations of psychiatric medicine while weighing other medical conditions and other medications. Patients are frequently on several medications for other medical conditions requiring careful management.

For example, in the first vignette, pre-service calls had to be made to the neurologist who follows his tremor and to the primary care physician who medicates his hypertension. The degree of hypomanic behavior has to be assessed and a focused neurologic examination had to be done to differentiate the benign tumor from lithium tremor and from senile or extrapyramidal tremor or tremor of other etiology before medication management was possible.

The vast majority (92 percent) of respondents consider the vignettes to be representative of their typical patients.

CMD Comments

06-Jul-95

Code: 90862

1995 RVUs: 0.95

Recommended RVUs: 0.55

Ratio: -0.42

Long Descriptor: Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

Reference Set (y/n): Y Global Period: XXX Frequency: 2,390,131 Impact: -956052.4

Source: 7

Year: 93

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
90862			
	99213 OFFICE/OUTPATIENT VISIT, EST	0.55	XXX

CMD Comment:

90862 is comparable to 99213. Standard of practice for this service is for 15 minutes of face to face time with a low level of stress and intensity. This code is abused because of its relatively high payment and low work requirement.

Societies Wishing to Survey: AACAP, AAP, ANA, APA

Societies Wishing to Comment: AAPM, APA-HCPAC, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90862	25.5	7.8	15.9	54.6	54.4	0.1	0.4	9.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90862	1878480	2602878	17.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90862	23.1	19.6	-1.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90862		
	general/family practice	2.3
	group practices	5.7
	other nonphysician prov	3
	psychiatry	87.2

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
90862		
290	2.2	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS
295	8.3	SCHIZOPHRENIC DISORDERS
296	8.1	AFFECTIVE PSYCHOSES
300	2	NEUROTIC DISORDERS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90862							
APA				0.82			
CMD		XXX	XXX	0.82	0.95	1.16	0.81

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90862								
APA							1.40	295
CMD	0.95	0.95	0.99	1.17	1.00	1.00	0.55	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
90862								
APA	XXX	0.82				28		9
CMD	XXX	0.82				28		9

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90862									
APA									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90862									
APA				1.40	0.95	py	n		0.023
CMD				0.55	0.95	py	n		0.023

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90870 Global Period: _____ Current RVW: 1.88 Recommended RVW: 2.19

CPT Descriptor:

Electroconvulsive therapy (includes necessary monitoring); single seizure.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Second ECT single seizure for 65 year old widower hospitalized with major depression. Stable medically.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Specialty: Survey results are unreliable: too few responses. Wide variation in data. respondents unable to find a reference service.

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time: _____ Total Time

Documentation of the service provided _____

Arranging for further services _____

Reviewing results of studies _____

Communicating further with patient, family, and other professionals including reports _____

Providing written or telephone reports to Medicare or other third party payors _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)			
2)			
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Given the unreliable survey results based upon: (1) low response rate; (2) wide variation in values; and (3) respondent inability to select a reference service, we have not based our recommendation on the survey results.

Instead, we recommend an RVU value of 2.19 for 90870 in order to preserve its relationship to 90844. The original Harvard study used 90844 as the anchor for the development of the relative values for the psychiatric codes. We recommend preserving this relationship and valuing 90870 at 2.19.

Public Comments06-Jul-95

Code: 90870

1995 RVUs: 1.88

Recommended RVUs: 2.58

Ratio:

Long Descriptor: Electroconvulsive therapy (includes necessary monitoring); single seizure

Reference Set (y/n): Y Global Period: 000 Frequency: 129,539 Impact: 90677

Source: 2 Year: 92 Public Comment Letter: 295

Reference Services:

CMD Comment:

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Societies Wishing to Survey: APA

Societies Wishing to Comment: AACAP, APA-HCPAC

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90870	44.1	10.3	2.9	70.9	25.1	0.5	0.3	6.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90870	128193	139648	4.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90870	72.2	64.1	-4.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90870	anesthesiology	3.3
	group practices	3.9
	psychiatry	90.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90870	295	2.8	SCHIZOPHRENIC DISORDERS
	296	20.1	AFFECTIVE PSYCHOSES

Public Comments

06-Jul-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90870							
APA		XXX	000	1.50	1.88	1.25	1.82

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90870								
APA	1.82	1.88	1.21	1.00	1.03	1.00	2.58	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
90870								
APA	000	1.50	t	.		23	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90870									
APA									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90870									
APA				2.58	1.88	py	n	0.065	

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90871 Global Period: _____ Current RVW: 2.72 Recommended RVW: 3.17

CPT Descriptor:

Electroconvulsive therapy (includes necessary monitoring); multiple seizures, per day.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Third session of Multiple Monitored ECT (MMECT) in a 46 year old woman with major depression. Two full seizures are to be included in this statement session.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:Specialty: Survey results are unreliable.

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time: _____ Total Time

Documentation of the service provided _____

Arranging for further services _____

Reviewing results of studies _____

Communicating further with patient, family, and
other professionals including reports _____Providing written or telephone reports to
Medicare or other third party payors _____**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)			
2)			
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Given the unreliable survey results based upon: (1) low response rate; (2) wide variation in values; and (3) respondent inability to select a reference service, we have not based our recommendation on the survey results. Instead, we recommend an RVU value of 3.17 for 90871 in order to preserve its current relationship to 90870.

Public Comments

06-Jul-95

Code: 90871 **1995 RVUs:** 2.72 **Recommended RVUs:** 3.52 **Ratio:**

Long Descriptor: Electroconvulsive therapy (includes necessary monitoring); multiple seizures, per day

Reference Set (y/n): N **Global Period:** 000 **Frequency:** 5,360 **Impact:** 4288

Source: 2 **Year:** 92 **Public Comment Letter:** 295

Reference Services:

CMD Comment:

--

Societies Wishing to Survey: APA

Societies Wishing to Comment: AACAP, APA-HCPAC

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90871	39.7	6.6	8.3	68.6	34.7	0	0	9.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90871	7035	6006	-7.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90871	73.1	64.8	-4.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90871	group practices	7.9
	psychiatry	87.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90871	244	1	ACQUIRED HYPOTHYROIDISM
	290	1.7	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS
	295	3.5	SCHIZOPHRENIC DISORDERS
	296	16.1	AFFECTIVE PSYCHOSES

Public Comments

06-Jul-95

300	4.3	NEUROTIC DISORDERS
310	1.2	SPECIFIC NONPSYCHOTIC MENTAL DISORDERS DUE TO ORGANIC BRAIN DAMAGE
401	1.2	ESSENTIAL HYPERTENSION
715	1	OSTEOARTHRISIS AND ALLIED DISORDERS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90871							
APA			000		2.72		2.72

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90871								
APA	2.72	2.72		1.00	1.00	1.00	3.52	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
90871								
APA	000							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
90871									
APA									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90871									
APA				3.52	2.72				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90880 Global Period: _____ Current RVW: 2.19 Recommended RVW: 2.19

CPT Descriptor: Medical Hypnotherapy

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service was felt to be overvalued. The American Psychological Association supports the American Psychiatric Association's assertion that the nature of psychiatric services has become more intensive over the past 5 years and believed it appropriate to develop survey data to determine the Relative Work Value of 90880. The present work value of 2.19 was assigned by HCFA in 1992.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

- #1: Referred by his neurologist, a 45-year-old man presented with chronic intractable pain that has not responded to medical intervention.
- #2: A 10-year-old girl was hit by a car eight months before. In the past six months, she has become afraid to cross any street and has to be carried or dragged by an adult. In the initial evaluation, she reported a number of symptoms of PTSD that had been worsening.

Description of Pre-Service Work:

Preparing to see patient and review of records. Communication with other providers as appropriate.

Description of Intra-Service Work:

History of problem and symptoms since last office visit and assessment of present mental status. Assessment of treatment efficacy since last visit and review of assignments with patient (or parents and patient when patient is a child). Hypnotic induction with patient and assessment of depth of trance state. Monitoring and management of patient response to hypnotherapy. Hypnotherapeutic work with special emphasis on suggestions to provide symptom reduction and symptom management (eg, pain control; anxiety management) with interpretation of present behavior and symptoms in context of their etiology and the patient's ability to change and control symptoms. Discussion of intersession assignments regarding behavior change with patient, and parents, if child.

Description of Post-Service Work:

Arranging next visit. Documentation of services including dictating report. Communication with third party payors as necessary. Periodic telephonic consultation with referring physician, other professionals, and family for continuity of care. Review of new medical or lab studies when relevant.

SURVEY DATA:Specialty: American Psychological AssociationSample Size: 120¹ Response Rate (%): 29%(35) Median RVW: 2.2325th Percentile RVW: 1.80 75th Percentile RVW: 2.31 Low: 1.35 High: 3.00Median Pre-Service Time: 8 Min. Median Intra-Service Time: 50 Min.25th Percentile Intra-Svc Time: 50 Min. 75th Percentile Intra-Svc Time: 60 Min. Low: 40 High: 90

Median Post-Service Time:	<u>Total Time</u>
Documentation of service provided	<u>10</u>
Arranging for further services	<u>5</u>
Reviewing results of studies	<u>5</u>
Communication further with patient, family, and other professionals including reports	<u>10</u>
Providing written or telephone reports to Medicare or other third party payors	<u>10</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99204	Office visit, moderate to high severity (45 minutes)	1.71
2)	99244	Office consultation, moderate to high severity (60 min)	2.23

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90880	8	50	40	4	4	3
99204	5	50	24	3	3	2.5
99244	5	52.5	25	3	3	3

¹The American Psychological Association sampled a total of 546 psychologists, of which 120 were targeted to this code.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The survey results support maintaining the current RVW value of 2.19 for 90880. The survey median RVW (2.23) is almost the same as the current value and the data does not support the assertion that the service is over-valued. The volume of this procedure is very low, with a frequency of 11,166 in 1994, as this procedure is not typically reimbursed by HCFA. However, payment policy does not change the relative work of providing the service. The American Psychiatric Association proposed a reduction in this value to 1.76 in their February 6, 1995 comment letter to HCFA, while proposing relative value increases of almost all other psychiatric procedures, citing a shift toward increased intensity and complexity of outpatient services over the past 5 years. This shift and complexity is not different for patients treated with 90880, medical hypnotherapy, which is rated as a more complex and intensive procedure than 90844, 45 - 50 minutes individual psychotherapy, (proposed RVW of 2.00) by psychologists.

Hypnotherapy is the application of hypnotic technique in the context of psychotherapy for treatment of mental/behavioral disorders, and is utilized in behavioral medicine for the control of pain, psychophysiological disorders, and behavioral disorders. Seventy-seven percent of our survey respondents report that the work of performing 90880 has changed in the past 5 years, with 63% of the sample reporting an increase in the complexity of the typical patient seen in the office. 100% of the sample reported that communication with third party payors has increased the work of providing this service, and 90% of the sample rated the vignette of the service as typical of their patients.

Public Comments

06-Jul-95

Code: 90880

1995 RVUs: 2.19

Recommended RVUs: 1.76

Ratio:

Long Descriptor: Medical hypnotherapy

Reference Set (y/n): N

Global Period: XXX

Frequency: 9,714

Impact: -4177

Source: 2

Year: 92

Public Comment Letter: 295

Reference Services:

CMD Comment:

Societies Wishing to Survey: APA-HCPAC

Societies Wishing to Comment: AACAP, AAP, APA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90880	2.2	0.4	7.8	88.5	78.4	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90880	3990	11166	67.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90880	27.2	23.8	-1.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90880	general/family practice	3
	other nonphysician prov	5.7
	psychiatry	40.6
	psychology	41.5
	rehabilitation medicine	5.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90880	296	4.1	AFFECTIVE PSYCHOSES
	300	8.1	NEUROTIC DISORDERS

Public Comments

06-Jul-95

304	1.5	DRUG DEPENDENCE
309	2	ADJUSTMENT REACTION
724	1.5	OTHER AND UNSPECIFIED DISORDERS OF BACK

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90880							
APA		XXX	XXX	1.03	2.19	2.13	2.19

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90880								
APA	2.19	2.19	2.13	1.00	1.00	1.00	1.76	295

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
90880								
APA	XXX	1.03				42		15

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90880									
APA									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90880									
APA				1.76	2.19	py	n		0.020

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90887 Global Period: _____ Current RVW: 1.48 Recommended RVW: 2.00

CPT Descriptor:

Interpretation or examination of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient.

Source and Summary of Comment to HCFA on this service:

The American Psychiatric Association's February 6 comments to HCFA indicated that this service is undervalued as the nature of psychiatric services has become more intensive since the development of existing work values. Also, HCFA failed to maintain the relative relationship among the psychiatric codes that was developed by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The father and stepmother of a 7 year old girl request an explanation of findings on their daughter whom the biological mother brought for evaluation. The biological parents share custody. The patient has been distractible, unable to learn to read, and has no friends. The father is financially responsible for medical treatment and wants to know why medication AND behavioral management are recommended.

Description of Pre-Service Work:

Review of the history, findings, and laboratory to present to the father and stepmother.

Description of Intra-Service Work:

Presentation of the findings and treatment recommendation, as well as review of the custody arrangement, the financial obligation of the father, and the rationale for the combination of medication and behavioral management.

Description of Post-Service Work:

Contact the biological mother to inform her of the process; perhaps contact the attorney.

SURVEY DATA:Specialty: Psychiatry (APA, AACAP), Psychology, NursingSample Size: 523¹ Response Rate (%): 23%(122) Median RVW: 2.025th Percentile RVW: 1.71 75th Percentile RVW: 2.25 Low: .5 High: 7.25Median Pre-Service Time: 10 Median Intra-Service Time: 50 Min.25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 60 Low: 15 High: 100

Median Post-Service Time:

Total TimeDocumentation of the service provided 8Arranging for further services 3Reviewing results of studies 2Communicating further with patient, family, and
other professionals including reports 10Providing written or telephone reports to
Medicare or other third party payors 5**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99404	Counseling and/or risk reduction interventions (60 minutes)	1.95
2)	99244	Office consultation (60 minutes)	2.23
3)	99386	Initial evaluation of healthy individual	1.88
4)	99204	Office visit (45 minutes)	1.71

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	<u>Pre</u>	<u>Intra</u>	<u>Post</u>	<u>Mental</u>	<u>Technical Skill and Physical Effort</u>	<u>Psychological Stress</u>
90887	10	50	28	4	4	3
99404	5	60	25	3	3	3
99244	5	60	37	4	4	3
99386	10	45	37	3	3	3
99204	10	45	38	3	3	3

¹ The American Psychological Association sampled a total of 546 psychologists, of which 186 were targeted to this code.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A recommended RVU value of 2.00 is supported by the survey results. This service was viewed as identical to 99404 (1.95) in terms of time but of higher intensity, thus 90887 should have a higher value than 99404. Similarly, this service is considered to be more time and higher intensity than both 99204 (RVU 1.71) and 99386 (1.88), although it is viewed as less time and intensity than 99244 (RVU 2.23). Given the relationship of 90887 to the reference services, a value of 2.00 is appropriate.

A higher work value for 90887 is also supported by the 64 percent of respondents who reported that the work associated with this service has changed over the past five years. Of these, three-quarters of respondents report that the complexity of patient problems being seen in the office has increased, while 61 percent report that the complexity of patient problems being seen in the hospital has increased. An analysis of Medicare data suggest that the usual site of service has shifted from the inpatient to outpatient setting. In 1988 51 percent of services for this code were performed in the inpatient setting. By 1994 this proportion declined to 25 percent. Finally, a large proportion of respondents report that the work of performing this service has increased in terms of coordinating with other health professionals (67 percent); documenting services (84 percent); and communicating with third party payers (93 percent).

The vast majority (81 percent) of respondents consider the vignettes to be representative of their typical patients.

CMD Comments

06-Jul-95

Code: 90887

1995 RVUs: 1.48

Recommended RVUs: 0.94

Ratio: -0.36

Long Descriptor: Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 45,103 **Impact:** -24355.62

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
90887			
	99214 OFFICE/OUTPATIENT VISIT, EST	0.94	XXX
	99215 OFFICE/OUTPATIENT VISIT, EST	1.51	XXX

CMD Comment:

CPT 99214, average 25 minutes, if spent entirely in counseling a family member or patient, would be 0.94. The intensity and time spent and interpreting to family regarding psychiatric problems is no different.

Societies Wishing to Survey: AACAP, AAP, AAPM, ANA, APA, APA-HCPAC

Societies Wishing to Comment: ACEP, ASIM, NASW, RPA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90887	50.7	16.8	16.1	60.5	30.7	0.2	0.9	3.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90887	16014	44266	66.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90887	32.4	24.8	-3.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90887		
	general/family practice	2.3
	group practices	4.9
	internal medicine	4
	other nonphysician prov	5.5
	psychiatry	63.4
	psychology	17.5

CMD Comments

06-Jul-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90887			
	290	4.5	SENILE AND PRESENILE ORGANIC PSYCHOTIC CONDITIONS
	293	1.8	TRANSIENT ORGANIC PSYCHOTIC CONDITIONS
	294	1.2	OTHER ORGANIC PSYCHOTIC CONDITIONS (CHRONIC)
	295	5.4	SCHIZOPHRENIC DISORDERS
	296	5.3	AFFECTIVE PSYCHOSES
	300	1.7	NEUROTIC DISORDERS
	301	1.9	PERSONALITY DISORDERS
	309	2.4	ADJUSTMENT REACTION

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90887								
	APA		XXX	XXX	1.49	1.48	0.99	1.48
	CMD		XXX	XXX	1.49	1.48	0.99	1.48

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90887									
	APA	1.48	1.48	0.99	1.00	1.00	1.00	2.56	295
	CMD	1.48	1.48	0.99	1.00	1.00	1.00	0.94	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
90887									
	APA	XXX	1.49	t	.		65	t	.
	CMD	XXX	1.49	t	.		65	t	.

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuis	Offvis
90887										
	APA	.	.	.	.	.	.	.	.	.
	CMD	.	.	.	.	.	.	.	.	.

Harvard Data:

CMD Comments

06-Jul-95

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
90887									
APA				2.56	1.48	py	n	0.023	
CMD				0.94	1.48	py	n	0.023	

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Integumentary

The codes in this section have been surveyed and commented on by numerous specialty societies. These societies wrote public comments on codes they believed were undervalued or overvalued. In several instances specialty societies were responding to reductions proposed by the Carrier Medical Directors.

Recommendations given by specialty societies were generally supported with survey data and arguments that were based on changes in the patient population, changes in technology, erroneous assumptions about the similarities between two codes and rank order anomalies. Survey sample sizes were generally of sufficient size to validate the results. Additionally, specialty societies made cross specialty comparisons to similar procedures. These gave support to arguments and survey data.

Generally the RUC found the data, comparisons and arguments convincing. The threshold for the RUC was to show compelling evidence that the procedure changed, the patient population changed, or that the code had been originally undervalued or overvalued. When the RUC recommended a different RVU, it typically attempted to rectify new survey data and rationale with Harvard data, producing final recommended RVU increases below those recommended by the specialty society. In all; 6 codes were reduced in value, 15 codes were increased in value, and for 35 codes the RUC recommended to retain the current value.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

*Key (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3= Adopt specialty/CMD recommended decrease; 4= Adopt increased RVU, but lower than specialty recommended; 5= Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
10040	Acne surgery	1.34	0.80	CMD: Reduce RVU to .80. This is a low intensity service that can be performed by a nurse under a physician's supervision. The HCFA data indicate an intra-operative time of 14 minutes. The intra-operative time of reference code 10060, <i>I&D of a simple abscess</i> , is 19 minutes. The average number of office visits in the follow-up period of acne surgery is 0.4 while it is 1.0 for the I&D of an abscess. Therefore, the RVUs for 10040 should be reduced to 0.8 which would place it at a level below the RVUs assigned to 10060 (1.12).	The RUC recommends that the CMD recommendation for a reduction be accepted.	3
10061	Drainage of skin abscess	2.48	2.24	Code 10061 is over valued by 10%. Comparable to 11603, <i>excision malignant lesion</i> , which is valued at 2.30.	The RUC recommends that the specialty societies recommendation for a reduction be accepted.	3
10080	Drainage of pilonidal cyst	1.62	1.12	CMD: Reduce RVU to 1.12. Service times are either equal or less than 10060, <i>I&D of a simple abscess</i> . The work involved in the I&D of a simple pilonidal cyst is comparable to the work involved in the I&D of an abscess yet the RVUs are significantly higher. The HCFA data indicate 15 minutes of intra-operative time for 10080 which is less than the intra-operative time for 10060 (19 minutes.) The intensity of the services is comparable. The RVUs for 10080 should be equivalent to the level of 10060 (1.12).	The RUC recommends that the CMD recommendation for a reduction be accepted.	3

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*Key (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3= Adopt specialty/CMD recommended decrease; 4= Adopt increased RVU, but lower than specialty recommended; 5= Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
10140	Drainage of hematoma/fluid	1.48	1.48	An individual commented that this code is over valued compared to 10160, Puncture drainage of lesion.	The argument is not compelling. No further evidence in the form of survey data or additional comparisons. The RUC recommends that the current value be maintained.	2
11000	Surgical cleansing of skin	0.91	0.60	CMD: Reduce to 0.45. This code is overvalued relative to code 11040, <i>debridement of the skin, partial thickness</i> . HCFA data indicates an intra-operative time of 73 minutes for code 11000. This is far too high since it is a very superficial debridement of eczematous skin of up to 10% of the body service. This takes simple cleansing of the skin with very little surgical debridement done, and certainly would not require 73 minutes. The operative time would compare more closely to code 11040, which has an operative time of 25 minutes, but it is not nearly as difficult as this. Therefore, the RVUs should be reduced to 0.45 which would be slightly below the RVUs (0.50) assigned to code 11040.	Surveys indicated a median intra-service time of 10 min. and a median RVU of 0.75 for 11000. 11040 has an intra-service time of 25 min. The RUC feels that the code is overvalued and should be reduced. The recommend RVU for 11000 is the average of the survey median RVU and the CMD recommended RVU. Payment policy 50% rule is applied to 11001.	3
11001	Additional cleansing of skin	0.45	0.30			3
11101	Biopsy, each added Lesion	0.41	0.41	Code is identical in work and intensity to 11100, <i>biopsy of skin</i> , which has an RVU of 0.81. 11101 should not fall under 50% rule for multiple surgical reductions.	Survey data show median intra-service time of 10 min. and a median RVU of 0.63. The description of this code as: each added lesion, indicates that it is intended to fall under 50% rule. The RUC recommends that the current RVU be maintained.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
11300	Shave skin lesion	0.51	0.51	CMD: All shaving for lesion codes RVUs should be reduced. The shaving of an epidermal or dermal lesion is overvalued compared to the excision of a benign lesion of the same size in the same location. It should be valued at 50% of the reference code because it requires less technical skill and physical effort, the mental effort and judgment are less, it takes less time and the stress is lower. Further, closure is not required and the global period is zero compared to the reference code with a global period of 10 days.	The whole family of shave excision codes were previously reviewed by the RUC and the results appeared in HCFA's December 2, 1993 final rule. At this time HCFA decided that the shave excision codes should be valued at 60% of the other excision codes, the 11400 series. The original RUC recommendation to HCFA suggested that the shave excision codes should be valued at 80% of the other excision codes. The current values are already below what the RUC recommended. Therefore, the current values should be maintained.	2
11301	Shave skin lesion	0.85	0.85			
11302	Shave skin lesion	1.05	1.05			
11303	Shave skin lesion	1.24	1.24			
11305	Shave skin lesion	0.67	0.67			
11306	Shave skin lesion	0.99	0.99			
11307	Shave skin lesion	1.14	1.14			
11308	Shave skin lesion	1.41	1.41			
11310	Shave skin lesion	0.73	0.73			
11311	Shave skin lesion	1.05	1.05			
11312	Shave skin lesion	1.20	1.20			
11313	Shave skin lesion	1.62	1.62			
11441	Removal of skin lesion	1.56	1.56	An individual commented that the charges for this procedure were excessive. The application of liquid nitrogen is not time consuming and is an insignificant cost. The physician work involved is minimal and does not require great skill.	The intention of the RUC and the 5-year review is to examine work values. The comment is based on charges which are not directly related to mission of the RUC. The RUC recommends that the current values be maintained.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
11731	Removal of second nail plate	0.55	0.57	Since the RVU for 11730, <i>removal nail plate</i> , is 1.13, the payment policy 50% adjustment for multiple procedures would increase the values for both codes.	The RUC recommends increasing the RVUs. The RVUs for both codes are increased to adjust the codes to 50% of the base code, 11730.	1
11732	Remove additional nail plate	0.38	0.57			1
11750	Removal nail bed	1.66	1.66	The RVU for 11752 should be greater than 28108, <i>Removal of toe lesions</i> , because not only is the tuft of the distal phalanx amputated, but the nail and nail matrix are also removed. APMA was not surveyed in original data collection conducted by Harvard, and yet podiatry performs the vast majority of services.	Survey data show median intra-service times of 15 and 25 min. and median RVUs of 2.50 and 3.40. Arguments for an increase are not compelling and survey results do not demonstrate need to raise RVUs. For 11752 Harvard's data collection showed 36 min. intra-service time which is longer than the survey results. The RUC recommends that the current values be maintained.	2 Add
11752	Remove nail bed/finger tip	2.37	2.37			2
11762	Reconstruction of nail bed	2.84	2.84	Correct value is 4.73 RVUs. Same elements of work as associated with 11750, <i>excision of nail and nail matrix</i> , and 15050, <i>pinch graft</i> . Should be greater than 15050 (3.90) because not only is the graphing procedure performed, but the nail and nail matrix are also removed. Feel that 100% of 3.90 should be added to 50% of 1.66.	Arguments for an increase are not compelling. The code was not surveyed. The RUC recommends that the current value be maintained.	2
11901	Added skin lesion injections	0.8	0.8	The RVU should be 1.34, the same as 10040, <i>acne surgery</i> . This procedure requires multiple injections into spots of 1 cm or larger. As a result, the procedure is more time intensive than the current RVU suggests.	Arguments for an increase are not compelling. The code was not surveyed. The RUC recommends that the current value be maintained.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
11960	Insert tissue expander(s)	6.04	8.00	Code should be increased to 9.37 RVUs. 11960 is comparable to 19357, <i>breast reconstruction</i> , at 16.72 RVUs. The only difference is that 19357 is normally more intense, except when tissue expansion occurs in the neck, face or scalp. The major change from the original RVU is that the Harvard survey only allowed for 3 post operation visits and the current number is 8.	Survey data show median intra-service time of 78 min. and a median RVU of 9.37. The argument rests on the increase in post service visits shown in survey results. The RUC recommends that the RVU be increased to 8.0 to accommodate the increase in post service time.	4
13132	Repair of wound or lesion	4.21	5.75	CMD: Increase RVU to 4.32; Code 13132 describes the complex repair of a 2.6 - 7.5 cm wound of the face. It is valued lower than the comparable repair of the scalp. This rank order is in conflict with the rank ordering of the codes for repairs of shorter wounds where the RVUs for the scalp procedure (code 13120, RVU = 3.25) are less than the RVUs for the face procedure (code 13131, RVU = 3.74). Compared to 13120 and 13121, the estimated work for 13132 should be higher than 13121, not less, since the face area is more complex and riskier.	Survey data show median intra-service time of 30 min. and a median RVU of 5.99. When repairing wound anatomy makes a difference. To correct rank order anomaly, the RUC recommends that the code should be valued in proportion to 13120 and 13121.	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
13131	Repair of wound or lesion	3.74	3.74	An individual commented that the whole series of complex laceration codes, 13131-13300, are undervalued. They felt that emergency room physicians were using these codes inappropriately since a specialist is usually called in for the truly complex procedures. Compare to scleral buckle for retinal detachment.	Arguments for an increase are not compelling. The specialty provided no evidence to support this comment. The RUC recommends that the current value be maintained.	2
13150	Repair of wound or lesion	3.76	3.76			
13151	Repair of wound or lesion	4.40	4.40			
13160	Late closure of wound	9.53	9.53			

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
15570	Form skin pedicle flap	3.75	8.39	All of these codes are undervalued. When compared to the corresponding adjacent flap codes, 14001 at 7.78, 14021 at 9.37 and 14040 at 7.18, the need for increased RVUs is apparent.	Situation in which old codes, 15500-15515, which were valued by Harvard, were deleted in 1992 and replaced with 15570-15576. The new codes are misvalued and no explanation has been received describing how the valuation of these codes was arrived at. The survey results show: a median RVU of 9.85 and a median intra-service time of 105 min for 15570; a median RVU of 9.63 and a median intra-service time of 90 min for 15572; a median RVU of 10.50 and a median intra-service time of 120 min for 15574; and a median RVU of 8.50 and a median intra-service time of 90 min for 15576. These results agree with the Harvard data for the original codes, 15500-15515. The survey results and lack of rationale for current RVUs supports the need for new RVUs. The RUC recommends that the codes should be valued at the same level established by Harvard for the original deleted codes.	4
15572	Form skin pedicle flap	3.80	8.59			
15574	Form skin pedicle flap	3.85	8.79			
15576	Form skin pedicle flap	4.27	7.85			

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
15580	Attach skin pedicle graft	3.30	9.00	This code is undervalued. It does not account for the intra-service time and work involved in harvesting and applying the skin graft. Compare to 15240, <i>skin full graft procedure</i> , and 15100, <i>skin split graft procedure</i> .	This code is now used for major reconstruction of the forehead. The current value does not include harvesting of the graft. Survey data show median intra-service time of 90 min. and a median RVU of 9.00. Survey results, rationale and comparisons provide compelling evidence to change the RVU. The RUC recommends that the RVU be increased.	1

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
15732	Muscle-skin graft, head/neck	12.10	16.52	A review of work involved and of service time data indicate that 15734 at 16.52 is the most difficult procedure of the family. 15732 and 15738 fall somewhere between 15734 and 15736. 15734 should be used as an anchor with the highest RVU followed by 15738, 15732, and 15736.	The entire family of codes are not aligned properly. CMD comments submitted to the February RUC meeting indicated that 15738 was "inconsistent with the other muscle flaps in this family" and should be increased to 15.26. This statement prompted the society to survey 15732, 15736 and 15738. Code 15734 is an accepted value on the MPC and is used as an anchor for all the codes. Compare the entire family of codes to 27165, <i>Incision/fixation of femur</i> , (16.38 RVUs and 147 min intra-service time) and to 42415, <i>Excise parotid gland/lesion</i> , (16.12 RVUs and 156 min intra-service time). 15732 and 15738 are similar in time and intensity to 15734. This assessment is supported by survey data. The survey data and comparisons are compelling. The RUC recommends that 15732 and 15738 should have their RVUs increased, while 15736 should remain at the current RVU.	4
15736	Muscle-skin graft, arm	15.26	15.26			2
15738	Muscle-skin graft, leg	10.07	16.52			4
15958	Remove thigh pressure sore	13.89	13.89	15958, <i>Remove thigh pressure sore with ostectomy</i> , is valued .04 RVUs lower than 15956, <i>Remove thigh pressure sore</i> , which does not specify ostectomy. The RVU of 15958 should be raised to account for the ostectomy.	Argument is not compelling. No further evidence is offered in the form of survey data or additional comparisons. The RUC recommends that the current value be maintained.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
16000	Initial treatment of burn(s)	0.89	0.89	An individual commented that this code is overvalued compared to 16020, <i>treatment of burns</i> .	The current relationship between 16000 and 16020 is acceptable. No further evidence is offered in the form of survey data or additional comparisons. The RUC recommends that the current value be maintained.	2
16035	Incision of burn scab	4.53	4.53	Global period of 90 days is incorrect. This should be deleted and the RVU should remain at 4.53.	The RUC recommends that the current value be maintained. The intention of the 5-year review is to consider changes in work. No compelling argument for change.	2
17000	Destroy benign/premal lesion	0.64	0.64	An individual commented that the charges for these procedures were excessive. The application of liquid nitrogen is not time consuming and is an insignificant cost. The physician work involved is minimal and does not require great skill. The society recommends that these codes maintain their current value.	The intention of the RUC and the 5-year review is to examine work values. The comment is based on charges which is not directly related to mission of the RUC. The current values should be maintained.	2
17001	Destruction of add'l lesions	0.19	0.19			2
17002	Destruction of add'l lesions	0.19	0.19			2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
17106	Destruction of skin lesions	4.54	4.54	CMD: reduce RVUs to 2.27, 5.06 and 7.10; When pre and post-service work are accounted for, the intra-service work is valued at over five times the intensity of the reference procedures. The reduction lowers the intensity to twice that of the reference procedures. Compares to 17000, <i>destroy benign lesion</i> , and 17100, <i>destruction of skin lesion</i> .	Survey results show median RVUs of 4.54, 9.06 and 13.10 and median intra-service times of 20 min, 30 min and 45 min. Work times and median RVU are comparable to current data. It is acceptable that the work and intensity is greater for lasers than for excisional procedures referenced by the CMDs. Survey results and rational substantiate maintaining the current values	2
17107	Destruction of skin lesions	9.06	9.06			2
17108	Destruction of skin lesions	13.10	13.10			2
19120	Removal of breast lesion	4.84	5.35	Code is undervalued by 17%. Code 19120 is comparable to 55530, <i>Revise spermatic cord veins</i> , which is valued at 5.45 RVUs.	Survey data show median intra-service time of 45 min. and a median RVU of 5.00. More frequent use of new technology diagnostic procedure, stereotactic needle biopsy, means that patients who under go this procedure are more likely to have cancer. Thus, the work intensity has increased. Survey and rational are compelling. However, the RUC recommends that the code only be increase in proportion to the 10 min. increase in intensity.	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
19140	Removal of breast tissue	4.90	4.85	Code 19140 is overvalued by 1%. Compare to 54520, <i>orchiectomy, simple</i> .	The requested decrease is less than 10% of the current RVUs for the service. The RUC did not believe its survey instrument to be sufficiently precise to detect such small changes, and recommends that the decrease be accepted.	3
19160	Removal of breast tissue	6.65	5.75	Code 19160 is overvalued by 14%. Compare to 43260, <i>ERCP</i> .		
19180	Removal of breast	8.15	8.09	Code 19180 is overvalued by 1%. Compare to 14060, <i>adjacent tissue transfer</i> .		
19318	Reduction of large breast	11.08	15.00	An individual commented that code 19318 is undervalued. Procedure is most commonly done as a bilateral procedure. Compare to 27130, <i>Hip reconstruction</i> , valued at 18.68, 35102, <i>Abdominal aortic aneurysm repair</i> , valued at 23.44, 55845, <i>Prostatectomy and lymphadenectomy</i> , valued at 26.73, and 63075, <i>Neurosurgical spinal cord discectomy</i> , valued at 19.77. In each of these cases the pre-, intra-, and post-service times are comparable with 19318.	Survey data show median intra-service time of 150 min. and a median RVU of 16.90. Greater intensity in that procedure requires that not only material be removed but also that the breast be reconstructed; skin and nipple. There is no Harvard data for this code and no basis for the current RVU. These survey results are the only data on this code and as a result the RUC recommends that the RVU be increased to the level of the survey median. Survey results and the lack of any basis for the current value are compelling reasons to change the RVU. However, the society recommended increase is too large.	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key*
19325	Enlarge breast with implant	8.05	8.05	Code 19325 is undervalued. This code should be made comparable to 19342, <i>Delayed breast prosthesis</i> , at 10.64	Survey data show median intra-service time of 90 min. and a median RVU of 8.5. The specialty recommended that the code should be increased to level of the survey median. However, the recommended increase is not significant. The RUC recommends that the current value be maintained.	2
19350	Breast reconstruction	8.21	8.52	Code 19350 is undervalued. The procedure should be valued as follows. 15200, <i>Full thickness skin graft</i> , valued at 7.46 and a small flap for the nipple reconstruction, 14000 (<i>skin tissue rearrangement</i>) at 5.43, would yield 10.16 after the 50% rule was applied to 14000.	Survey data show median intra-service time of 90 min. and a median RVU of 10.00. The code is a combination of 14040, <i>skin tissue rearrangement</i> , and 15200, <i>skin full graft procedure</i> . Such a combination with a normal 50% reduction would produce a an RVU of 11.00. Since the Survey validates the Harvard data, this original Harvard derived value is recommended by the RUC.	4

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11000 Global Period: 000 Current RVW: 0.91

Recommended RVW: 0.75

CPT Descriptor:

Debridement of extensive eczematous or infected skin; up to 10% of body surface

Source and Summary of Comment to HCFA on this service:

The Medicare Carrier Medical Directors recommended a decrease in RVW from 0.91 to 0.45. APMA agrees that 11000 is overvalued, but that RVW should be decreased to 0.75.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 65 year-old female undergoes the debridement of infected skin from the 4th digital interspace right foot, in office.

Description of Pre-Service Work:

Review of chart with general medical history update including current medications and any allergies. Physical examination includes evaluating the neurological and vascular status of the patient, along with a dermatologic examination. The procedural work is explained to the patient and the instruments used in treatment are removed from the sterilizer. A culture and sensitivity may be taken from the infected skin. The patient's vital signs are taken. The patient is placed in the supine position and the foot is prepped in an aseptic manner. Suitable local anesthesia may be administered.

Description of Intra-Service Work:

In a sterile field, using both sharp and blunt dissection the infected skin is debrided with care being taken to identify and to retract away any vital structures. The area is flushed with copious amounts of sterile saline. A sterile dressing is applied.

Description of Post-Service Work:

A surgical shoe may be fitted on the patient. The patient is instructed on the care of the wound. Homecare instructions are given and explained to the patient. Appropriate antibiotic prescriptions are given to the patient. The doctor discusses future management and follow-up as necessary, including analyzing laboratory results. The medical record is completed. Also, a note to the referring physician is dictated as to the course and outcome of treatment and future management.

SURVEY DATA:

Specialty: Podiatric Medicine

Sample Size: 87/88 Response Rate (%): 100 Median RVW: 0.75

25th Percentile RVW: 0.5 75th Percentile RVW: 1.1 Low: 0.35 High: 9.5

Median Pre-Service Time: 5 Median Intra-Service Time: 10

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 15

Low: 2 High: 45

<u>Median Post-Service Time:</u>	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	5	
ICU:	NA	NA
Other Hospital:	NA	NA
Office:	NA	NA

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	11040	Debridement; skin, partial thickness	0.50
2)	10060	Incision and drainage of abscess (eg carbuncle, suppurative hidradenitis, cutaneous or sub-cutaneous abscess, cyst, furuncle, or paronychia); simple or single	1.12

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The surveys indicated that the pre-, intra-, and post-service time and intensity of 10060 was approximately 30% greater than 11000. Most of the difference was due to the post-service time included in the 10060 ten day global period. The cumulative pre-, intra-, and post-service time and intensity of 11040 was approximately 20% less than 11000.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The correct RVW for 11000 should be 0.75 and not the current value 0.91 or the 0.45 recommended by the CMDs. The pre-, intra-, and post-service time and intensity of 11000 is the same as reference procedure 10060 (RVW 1.12) except for the increased time included in the 10 day global period which accounted for the 30% greater values obtained from the survey. Additionally, reference procedure 11040 (RVW 0.50) was valued 20% less than 11000. This is probably due to the fact that there is greater intensity and effort in treating infected skin.

CMD Comments

30-Jun-95

Code: 11000

1995 RVUs: 0.91

Recommended RVUs: 0.45

Ratio: -0.51

Long Descriptor: Debridement of extensive eczematous or infected skin; up to 10% of body surface

Reference Set (y/n): N **Global Period:** 000 **Frequency:** 495,028 **Impact:** -227712.88

Source: 4 **Year:** 94 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
11000			
	11040 SURGICAL CLEANSING, ABRASION	0.50	000

CMD Comment:

This code is overvalued relative to code 11040 (debridement of the skin, partial thickness). HCFA data indicates an intra-operative time of 73 minutes for code 11000. This is far too high since it is a very superficial debridement of eczematous skin of up to 10% of the body service. This takes simple cleansing of the skin with very little surgical debridement done, and certainly would not require 73 minutes. The operative time would compare more closely to code 11040, which has an operative time of 25 minutes, but it is not nearly as difficult as this. Therefore, the RVUs should be reduced to 0.45 which would be slightly below the RVUs (0.50) assigned to code 11040.

Societies Wishing to Survey: APMA

Societies Wishing to Comment: AAD, AAFPRS, ACEP, ACS, AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
11000	58.5	20.1	13.8	61.7	8	0.7	2.3	7.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
11000	582681	534725	-4.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
11000	2.4	2.3	-0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
11000		
	dermatology	3.6
	general surgery	4.6
	general/family practice	3.1
	podiatry	83.6

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

ICD9	Pct of Time Used	ICD9 Descriptor
11000		
110	3.7	DERMATOPHYTOSIS
250	5.4	DIABETES MELLITUS
443	1.4	OTHER PERIPHERAL VASCULAR DISEAS
681	2.3	CELLULITIS AND ABSCESS OF FINGER A
682	1.3	OTHER CELLULITIS AND ABSCESS
686	2	OTHER LOCAL INFECTIONS OF SKIN AN
703	1.9	DISEASES OF NAIL
707	12.8	CHRONIC ULCER OF SKIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
11000							
CMD		000	000	3.93	0.91	0.23	0.91

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
11000								
CMD	0.91	0.91	0.23	1.00	1.00	1.00	0.45	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notatt	Imppt
11000								
CMD	000	3.93		12		73		12

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
11000									
CMD		0.5		10	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
11000									
CMD		0		0.45	0.91	gs	3		0.047

CMD Comments

30-Jun-95

Code: 11001 **1995 RVUs:** 0.45 **Recommended RVUs:** 0.23 **Ratio:** -0.49

Long Descriptor: Debridement of extensive eczematous or infected skin; each additional 10% of the body surface

Reference Set (y/n): N **Global Period:** ZZZ **Frequency:** 12,120 **Impact:** -2666.4

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
11001			
	11000 SURGICAL CLEANSING OF SKIN	0.91	000

CMD Comment:

Much of the work in 11000 is in preparation, so 11001 adds relatively little work, probably no more than 5 minutes of simple cleansing with little actual surgical debridement. This code is currently valued at 1/2 the value of 11000. This value represents intra-operative work only and the code is not subject to multiple surgical reductions. To maintain the correct relationship to code 11000, the recommended value is 1/2 of the recommended value for 11000.

Societies Wishing to Survey: APMA

Societies Wishing to Comment: AAD, AAFPRS, ACEP, ACS, AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
11001	58.4	25	40.3	67.9	14.3	1	4.2	5.5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
11001	6862	12386	34.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
11001	6.2	4.9	-0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
11001		
	dermatology	3.1
	general surgery	9.5
	general/family practice	2.4
	internal medicine	3.4
	podiatry	77.3

Claims-Level Diagnosis Information:

CMD Comments

	ICD9	Pct of Time Used	ICD9 Descriptor
11001			
	110	7.5	DERMATOPHYTOSIS
	250	3.8	DIABETES MELLITUS
	681	2.8	CELLULITIS AND ABSCESS OF FINGER A
	686	3.8	OTHER LOCAL INFECTIONS OF SKIN AN
	703	3.7	DISEASES OF NAIL
	707	7.6	CHRONIC ULCER OF SKIN
	709	6.7	OTHER DISORDERS OF SKIN AND SUBCU
	757	3.6	CONGENITAL ANOMALIES OF THE INTE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
11001							
CMD		ZZZ	ZZZ	2.95	0.45	0.15	0.45

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
11001								
CMD	0.45	0.45	0.15	1.00	1.00	1.00	0.23	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
11001								
CMD	ZZZ	2.95	t					

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
11001									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
11001									
CMD				0.23	0.45	gs	3		



American Podiatric Medical Association, Inc.

Treasurer

Marc D. Lenet, DPM
5508 Belair Road
Baltimore, Maryland 21206

June 27, 1995

11731 Avulsion of nail plate, partial or complete, simple; second nail plate

The fee schedule assigned 1.13 as the RVW for 11730 (Avulsion of nail plate, partial or complete, simple; single). The correct RVW for 11731 should be 0.57. We agree with the concept of reduced payment levels for multiple surgeries, but we feel that to be consistent with the established scale of 50% reduction for a second procedure that the RVW for 11731 should be 50% of 1.13 (0.57) and not 0.55.

11732 Avulsion of nail plate, partial or complete, simple; each additional nail plate

As with procedure 11731, the RVW established by the fee schedule is 1.13 for 11730. The correct RVW for 11732 should be 0.57 and not 0.38. We strongly feel that multiple surgery performed on the extremities, and in particular the digits, is generally substantially different than multiple operations performed in other parts of the body. When 11732 is performed in addition to 11730 and 11731 it may require separate administration of local anesthesia (these procedures are typically performed under local anesthesia, frequently through digital blocks); separate incisions are required for each digit; the identical intraoperative work is performed as for 11730; each digit requires individual postoperative dressings; the time required to perform each nail avulsion is the same as 11730; the mental effort and judgment, technical skill and physical effort, and psychological stress are at least the same as 11730, but probably greater due to the increased risk to the patient of infection, vascular compromise and disability; postoperative visits for multiple digital procedures usually requires more time for each visit as well as an increased number of visits.

Public Comments

30-Jun-95

Code: 11731

1995 RVUs: 0.55

Recommended RVUs: 0.57

Ratio:

Long Descriptor: Avulsion of nail plate, partial or complete, simple; second nail plate

Reference Set (y/n): N Global Period: ZZZ Frequency: 195,345 Impact: 3907

Source: 5 Year: 93 Public Comment Letter: 216

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAD, AAP, ACEP, APMA, APSA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
11731	64.1	22.3	21.9	71.9	7.2	0	0.6	4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
11731	229135	204696	-5.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
11731	0.8	0.9	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
11731	podiatry	99

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
11731	110	3.4	DERMATOPHYTOSIS
	250	1.9	DIABETES MELLITUS
	443	1.5	OTHER PERIPHERAL VASCULAR DISEAS
	681	2	CELLULITIS AND ABSCESS OF FINGER A
	703	24.4	DISEASES OF NAIL
	729	1.3	OTHER DISORDERS OF SOFT TISSUES

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
11731							
APMA		ZZZ	ZZZ	0.64	0.55	0.86	0.38

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
11731								
APMA	0.55	0.55	0.59	1.45	1.00	1.00	0.57	216

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
11731								
APMA	ZZZ	0.64		2	*	20		2

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
11731									
APMA	*	0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
11731									
APMA	*	0		0.57	0.55	gs	3		0.028

Public Comments

30-Jun-95

Code: 11732

1995 RVUs: 0.38

Recommended RVUs: 0.57

Ratio:

Long Descriptor: Avulsion of nail plate, partial or complete, simple; each additional nail plate

Reference Set (y/n): N Global Period: ZZZ Frequency: 16,511 Impact: 3137

Source: 4 Year: 93 Public Comment Letter: 216

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAD, AAP, ACEP, APMA, APSA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
11732	66.8	21.2	38.7	72.9	4.8	0	0	7.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
11732	21518	19026	-6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
11732	2.5	1.3	-0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
11732	podiatry	94

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
11732	110	6.3	DERMATOPHYTOSIS
	250	4	DIABETES MELLITUS
	443	2.8	OTHER PERIPHERAL VASCULAR DISEAS
	681	1.6	CELLULITIS AND ABSCESS OF FINGER A
	700	1.1	CORNS AND CALLOSITIES
	703	22.6	DISEASES OF NAIL

Public Comments

30-Jun-95

715	3.8	OSTEOARTHRISIS AND ALLIED DISORD
735	1.3	ACQUIRED DEFORMITIES OF TOE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
11732							
APMA		ZZZ	ZZZ	0.54	0.38	0.70	0.38

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
11732								
APMA	0.38	0.38	0.70	1.00	1.00	1.00	0.57	216

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
11732								
APMA	ZZZ	0.55	t					

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
11732									
APMA		0.0		0	0.0		0		

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
11732									
APMA				0.57	0.38	gs	3		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11960 **Global Period:** 090 **1995 RVW:** 6.04 **Recommended RVW:** 9.37

CPT Descriptor: Insertion of tissue expander(s) for other than breast, including subsequent expansion.

Source and Summary of Comment to HCFA on this service: An Advisory Panel of surgeons representing the American Society of Plastic and Reconstructive Surgeons, the American Society of Maxillofacial Surgeons, the American Society for Reconstructive Microsurgery, the American Association for Hand Surgery, the American Association of Plastic Surgeons, and the American Society for Aesthetic Plastic Surgery reviewed the RVW relationship for the (Medicare) top ranked surgical codes for plastic and reconstructive surgery. The results of this review found code 11960 to be currently undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 67-year old man underwent a complete rhinectomy by the Moh's technique for invasive basal cell carcinoma. The wound is healed well. Complete physical examination indicates no evidence of metastatic disease. The nasal reconstruction was planned, utilizing expanded forehead skin. At operation, an incision was made in the right temple and scalp and the forehead was completely undermined at the level of the gales. An appropriately sized and shaped tissue expander is placed in the pocket and the filling port was placed in a random spot. This wound is closed in layers in the usual fashion. Post-operatively, the patient is seen at 4-7 day intervals for a total of 6-10 visits to add saline to the tissue expander until it reaches requisite capacity.

Description of Pre-Service Work:

After the decision to operate is made, pre-service work begins on the day before surgery and continues until the time of the procedure. This work includes obtaining and reviewing pre-procedural laboratory, pathology, and imaging studies; and communicating with the patient (and/or the patient's family) to review the operative risks and benefits, and to obtain informed consent. Other preoperative services include personal and patient preparation; and monitoring of the induction of anesthesia; supervision of the positioning, preparing and draping of the patient; and ensuring that the appropriate surgical instruments and supplies are available, including the prosthesis.

Description of Intra-Service Work:

After anesthesia is satisfactorily established, the appropriate operative plan is transferred to the forehead. The incision is made in the forehead or scalp and carried down to the level of the galea. A sufficient pocket is created by undermining at this level to accommodate the expander and a distant filling port if used. The tissue expander is checked for integrity with pressure under saline and then placed in the prepared pocket. The wound is closed in layers. A dry sterile dressing is applied and the patient monitored during emergence from anesthesia.

Description of Post-Service Work:

Post-service work begins with communication of the operative procedure to the patient's family and other health care professionals as appropriate. A surgical report is prepared for the chart and dictated to the medical record. Post-operative orders are written. Discharge planning is supervised and instructions given.

Post-operative office visits allow monitoring of the skin closure until sufficient healing has occurred to allow initiation of tissue expansion. Expansion is accomplished by percutaneous introduction of normal saline into the distant filler port. The volume of expansion is determined at the time of each visit relative to the clinical situation. The number of expansion procedures and the volume of saline injected is determined by the goals of the reconstruction. This sequence of expansion typically takes approximately ten office visits, which occur on a weekly basis.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.
American Academy of Otolaryngology - Head and Neck Surgery, Inc.

	Survey n:	200	PRE	INTRA	POST								
					Response:	54	Day 1	ICU		Hosp. - Other		Office	
								Rate %:	27%	total min	# visits	total min	# visits
RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits				
low	5.50		20										
25th %	7.00		60										
med	9.37	60	78	30	0	0	10	1	150	8			
75th %	11.00		90										
high	16.00		240										

KEY REFERENCE SERVICE(S):

1995 RVW Global CPT Descriptor

16.72 090 19357 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The work of 11960 is comparable, but may not be more intense than the work of CPT 19357 as the operative design and execution is usually more complex and, therefore, the planning requires more intensity and planning. Examples where 11960 has a higher intensity than 19357 include procedures for the expansion of the neck for reconstruction of the face, or expansion of the scalp in a child for reconstruction after excision of a congenital nevus.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This procedure has allowed reconstructive efforts to replace unique tissue losses with "like" tissue. As mentioned above, this procedure entails detailed planning and is patient-specific but is not as intense as 19357.

The work of performing this service has not changed in the last five years and is felt to be of moderate intensity by almost all who participated in the survey.

Public Comments

30-Jun-95

Code: 11960

1995 RVUs: 6.04

Recommended RVUs: 16.00

Ratio:

Long Descriptor: Insertion of tissue expander(s) for other than breast, including subsequent expansion

Reference Set (y/n): N Global Period: 090 Frequency: 304 Impact: 3028

Source: 2 Year: 92 Public Comment Letter: 307

Reference Services:

CMD Comment:

--

Societies Wishing to Survey: AAO-HNS, ASPRS

Societies Wishing to Comment: AAD, AAFPRS, AAP, AOA, APSA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
11960	25	0	0	75	25	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
11960	378	372	-0.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
11960	42.3	44.6	1.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
11960	dermatology	9.1
	general surgery	3.8
	group practices	3.8
	orthopedic surgery	3.2
	other nonphysician prov	2.2
	otolaryngology	4.3
	plastic surgery	69.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
11960			

Public Comments

30-Jun-95

173	6.3	OTHER MALIGNANT NEOPLASM OF SKIN
873	12.5	OTHER OPEN WOUND OF HEAD
941	6.3	BURN OF FACE, HEAD, AND NECK
V10	12.5	PERSONAL HISTORY OF MALIGNANT NE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
11960							
ASPRS		090	090	6.48	6.04	0.93	6.04

Harvard Data:

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
11960								
ASPRS	6.04	6.04	0.93	1.00	1.00	1.00	16.00	307

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
11960								
ASPRS	090	6.48		31	*	92		30

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
11960									
ASPRS	*	1.0	*	10	0.5	*	15	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
11960									
ASPRS	*	15		16.00	6.04	ps	3		0.035

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 13132 **Global Period:** 010 **1995 RVW:** 4.21 **Recommended RVW:** 5.99

CPT Descriptor: Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm

Source and Summary of Comment to HCFA on this service: 13132 was found to be undervalued by the Medicare Carrier Medical Directors.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 27 year old female presents to the emergency room with a 3.5 cm curvilinear jagged laceration of the cheek, as well as other abrasions, following a rollerblading accident. She had no loss of consciousness and no other maxillofacial or skeletal injuries. Services of a specialized surgeon were requested.

Description of Pre-Service Work:

This service is typically rendered in the emergency department. A physician must assess the patient and review the existing emergency department evaluation. Once the decision to render care has been made, the pre-service work then begins.

The typical patient is informed of the treatment to be rendered, the manner in which it is to be rendered, and this information is communicated to the patient's family, if appropriate, and other health care professionals.

Description of Intra-Service Work:

Intra-service work, in this instance, includes the introduction of local anesthesia, preparation of the skin, and appropriate drape. Routine debridement of the skin edges to remove ragged tissue and embedded dirt and foreign material precedes layered closure.

Appropriate topical antibiotics and dry sterile dressings are applied.

Description of Post-Service Work:

Post-service work includes post-operative instructions regarding wound care, arrangement for follow-up visit, and communication of operative findings with the patient, the family, and appropriate health professionals. Written reports are prepared.

Although typically two or three post-operative visits are required for wound care and suture removal, all routine services performed within the 90-day global period are included. Frequently, the location and nature of the scar requires a follow-up office visit at 3 to 4 months.

CMD Comments

30-Jun-95

Code: 13132

1995 RVUs: 4.21

Recommended RVUs: 4.32

Ratio: 0.03

Long Descriptor: Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm

Reference Set (y/n): N **Global Period:** 010 **Frequency:** 33,787 **Impact:** 3716.57

Source: 4 **Year:** 93 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
13132			
13120	REPAIR OF WOUND OR LESION	3.25	010
13121	REPAIR OF WOUND OR LESION	4.28	010

CMD Comment:

Code 13132 describes the complex repair of a 2.6 - 7.5 cm wound of the face. It is valued lower than the comparable repair of the scalp. This rank order is in conflict with the rank ordering of the codes for repairs of shorter wounds where the RVUs for the scalp procedure (code 13120, RVU = 3.25) are less than the RVUs for the face procedure (code 13131, RVU = 3.74). Compared to 13120 and 13121, the estimated work for 13132 should be higher than 13121, not less, since the face area is more complex and riskier.

Societies Wishing to Survey: AAO-HNS, AAP

Societies Wishing to Comment: AAD, AAFP, AAFPRS, AAO-HNS, ACEP, ACS, AOA, APMA, APSA, ASPRS, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
13132	53.4	13.9	3.3	45.9	4	0.3	0.5	6.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
13132	29527	35797	10.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
13132	4.9	3.9	-0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
13132		
	dermatology	59.4
	emergency medicine	3.6
	general surgery	4.1
	general/family practice	4.5
	otolaryngology	2.4
	plastic surgery	20.1

CMD Comments

30-Jun-95

Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
13132		
173	17.3	OTHER MALIGNANT NEOPLASM OF SKIN
216	1.8	BENIGN NEOPLASM OF SKIN
238	1.2	NEOPLASM OF UNCERTAIN BEHAVIOR O
702	1.6	OTHER DERMATOSES
873	3.8	OTHER OPEN WOUND OF HEAD
883	1.3	OPEN WOUND OF FINGER(S)

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
13132							
CMD		010	010	3.33	4.21	1.26	4.21
IND		010	010	3.33	4.21	1.26	4.21

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
13132								
CMD	4.21	4.21	1.26	1.00	1.00	1.00	4.32	
IND	4.21	4.21	1.26	1.00	1.00	1.00	INCR	150

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
13132								
CMD	010	3.33		18		50		22
IND	010	3.33		18		50		22

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
13132									
CMD		0.0		0	0.0		0	0.0	1.0
IND		0.0		0	0.0		0	0.0	1.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
13132									
CMD		10		4.32	4.21	ps	n		0.041
IND		10		INCR	4.21	ps	n		0.041

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 15570 **Global Period:** 090 **1995 RVW:** 3.75 **Recommended RVW:** 9.85

CPT Descriptor: Formation of direct or tubed pedicle, with or without transfer, trunk

Source and Summary of Comment to HCFA on this service: An Advisory Panel of surgeons representing the American Society of Plastic and Reconstructive Surgeons, the American Society of Maxillofacial Surgeons, the American Society for Reconstructive Microsurgery, the American Association for Hand Surgery, the American Association of Plastic Surgeons, and the American Society for Aesthetic Plastic Surgery reviewed the RVW relationship for the (Medicare) top ranked surgical codes for plastic and reconstructive surgery. The results of this review found code 15570 to be currently undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Patient has a large thoraco-abdominal tumor which will require a full thickness chest wall resection and subsequent reconstruction. The ipsilateral latissimus dorsi muscle is unavailable due to a previous thorotomy and a thoraco-epigastric tubed pedicle is chosen for reconstruction. At operation, the abdominal skin is appropriately measured. The dimensions are taken and the skin is elevated and tubed. The thoraco-abdominal skin beneath the tube is then advanced for primary closure.

Description of Pre-Service Work:

Pre-service work begins the day before the surgery and continues until the time of the procedure. This includes obtaining and reviewing pre-procedural pathology, laboratory, and imaging studies; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include personal and patient preparation; supervision of the positioning, prepping, and draping of the patient; and ensuring that appropriate surgical instruments are necessary are present.

Description of Intra-Service Work:

At operation, the plan design is re-evaluated, and the design transferred to the abdominal skin. After anesthesia is achieved, the skin is incised and dissection is carried down to the superficial fascia on both sides of the proposed tube. The tube pedicle is formed and that incision is closed. The donor defect then created is closed by abdominal wall tissue advancement. Appropriate dressings designed to protect the tube pedicle and allow primary wound healing.

Description of Post-Service Work:

Post-service work begins with communication with the family and other health care professionals (including written and oral reports and orders). All hospital visits and services performed by the surgeon; such as monitoring and care of the incision; and antibiotic and pain medication management. Discharge management includes the surgeon's instructions for continuing care, and preparation of discharge records. All post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure including removal of sutures.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

Survey n:	150	PRE	INTRA	POST							
Response:	28			Day 1 total min	ICU		Hosp. - Other		Office		
Rate %:	19%	RVW	total min		total min	total min	# visits	total min	# visits	total min	# visits
	low	6.00		60							
	25th %	8.32		90							
	med	9.85	60	105	30	0	0	30	3	53	3
	75th %	11.48		120							
	high	20.00		240							

KEY REFERENCE SERVICE(S):

1995 RVW	Global	CPT	Descriptor
7.78	090	14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
9.37	090	14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
7.18	090	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
8.05	090	14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
8.39*		15500	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on trunk (deleted 1992 and replaced with 15570)</i>
8.59*		15505	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on scalp, arms, or legs (deleted 1992 and replace with 15572)</i>
8.97*		15510	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on forehead cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet (deleted 1992 and replaced with 15574)</i>
7.85*		15515	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on eyelids, nose, ears, or lips (deleted 1992 and replaced with 15576)</i>
3.75	090	15570	Formation of direct or tubed pedicle, with or without transfer; trunk
3.80	090	15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
3.85	090	15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
4.27	090	15576	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral

*This RVW is based on Harvard Phase 3 crosswalked work values and has been scaled to the 1995 MFS.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT	Data Source (Harvard / 5- Yr)	Time in Minutes			
		Pre-service	Intra-service	Post-service (hospital)	Post-service (office)
14001	Harvard (P3)	49	105	48	63
14021	Harvard (P3)	52	116	54	68
14040	Harvard (P4)	45	92	45	63
14060	Harvard (P3)	21	60	24	66
15500*	Harvard (P3)	64	99	67	69
15505*	Harvard (P3)	61	93	66	67
15510*	Harvard (P3)	51	96	80	66
15515*	Harvard (P3)	51	90	73	67
15570	ASPRS 5-Yr	60	120	65	60
15572	ASPRS 5-Yr	43	105	60	60
15574	ASPRS 5-Yr	60	120	90	53
15576	ASPRS 5-Yr	45	90	45	60

*Codes 15500-15515 were deleted in 1992 and replaced with codes 15570-15576.

(P3) denotes Harvard Phase 3

(P4) denotes Harvard Phase 4, refinement

Codes 15500, 15505, 15510, and 15515 were studied as part of the Harvard Phase 3. The results of the study are presented in the table above. The cross-specialty crosswalk work values for these four codes equated to the 1995-scaled RVWs presented under Key References above. In 1992 these codes were deleted and replaced by 15570-15576, however, the published RVWs were reduced **significantly** from the Harvard study values. The survey data for 15570-15576 confirms the time information gathered in the Harvard Study and emphasizes the undervaluation of these codes.

In addition, the work of 15570, 15572, 15574, and 15576 is comparable to the corresponding adjacent flap codes in the range 14001-14060 (see tables above). These codes, also, have significantly higher RVWs than 15570-15576.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The discussion presented above, that compares the RVWs for 15570, 15572, 15574, and 15576 with the RVWs for similar key reference services, emphasizes the undervaluation of these codes based on time alone. The following RVWs are recommended: [15570; RVW=9.85]; [15572; RVW=9.63]; [15774; RVW=10.50]; [15776; RVW=8.50].

As noted above, with the CPT realignment the values have been arbitrarily reduced. Because of this action, ASPRS has resurveyed these four codes and presents this information. It is acknowledged that the numbers of respondents are less than 30, but the RUC should be aware that this family of codes are rarely used and finding ASPRS members who have performed this procedure within the last 12 months was difficult. Review of the survey data with knowledgeable plastic surgeons confirms the relativity of these submitted work values.

The intensity, work and visits of this code have not changed in the last five years.

Public Comments

30-Jun-95

Code: 15570

1995 RVUs: 3.75

Recommended RVUs: 9.00

Ratio:

Long Descriptor: Formation of direct or tubed pedicle, with or without transfer, trunk

Reference Set (y/n): N Global Period: 090 Frequency: 459 Impact: 2410

Source: 4 Year: 93 Public Comment Letter: 307

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ASPRS

Societies Wishing to Comment: AAD, AAFPRS, AAO-HNS, AOA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
15570	25	0	0	25	12.5	0	0	0

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
15570	558	520	-3.5

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
15570	44.8	44.2	-0.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
15570	general surgery	23.8
	otolaryngology	6.2
	plastic surgery	58.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
15570	040	3.1	OTHER BACTERIAL DISEASES
	173	31.3	OTHER MALIGNANT NEOPLASM OF SKIN
	174	3.1	MALIGNANT NEOPLASM OF FEMALE BR
	195	3.1	MALIGNANT NEOPLASM OF OTHER AND

Public Comments

30-Jun-95

233	3.1	CARCINOMA IN SITU OF BREAST AND G
692	3.1	CONTACT DERMATITIS AND OTHER ECZ
875	3.1	OPEN WOUND OF CHEST (WALL)

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
15570							
ASPRS			090		3.75		3.75

Harvard Data:

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
15570								
ASPRS	3.75	3.75		1.00	1.00	1.00	9.00	307

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
15570								
ASPRS	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
15570									
ASPRS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
15570									
ASPRS				9.00	3.75				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 15572 **Global Period:** 090 **1995 RVW:** 3.80 **Recommended RVW:** 9.63

CPT Descriptor: Formation of direct or tubed pedicle, with or without transfer; scalp, arms or legs

Source and Summary of Comment to HCFA on this service: An Advisory Panel of surgeons representing the American Society of Plastic and Reconstructive Surgeons, the American Society of Maxillofacial Surgeons, the American Society for Reconstructive Microsurgery, the American Association for Hand Surgery, the American Association of Plastic Surgeons, and the American Society for Aesthetic Plastic Surgery reviewed the RVW relationship for the (Medicare) top ranked surgical codes for plastic and reconstructive surgery. The results of this review found code 15572 to be currently undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 23-year old female who sustained full thickness burns of her scalp was reconstructed primarily with a split thickness skin graft. The defect has been reconstructed with tissue expansion of hair bearing scalp and the patient has now had full expansion. At operation, the incision is made. The tissue expander is removed (separate CPT code, #11971). The residual scalp skin after expansion is designed and tailored to fit the previous skin graft. This skin graft is removed. The flap is usually rotated and/or advanced into position and wound closure is accomplished.

Description of Pre-Service Work:

Pre-service work begins the day before the surgery and continues until the time of the procedure. This includes obtaining and reviewing pre-procedural pathology, laboratory, and imaging studies; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include personal and patient preparation; supervision of the positioning, prepping, and draping of the patient; and ensuring that appropriate surgical instruments are necessary are present.

Description of Intra-Service Work:

After anesthesia is induced, the tissue expander is exposed and removed (11971). The expanded tissue is formed into a flap and inset into the defect, and secure in place. A dry sterile dressing is applied.

Description of Post-Service Work:

Post-service work begins with communication with the family and other health care professionals (including written and oral reports and orders). All hospital visits and services performed by the surgeon, including monitoring and care of the incision, and antibiotic and pain medication management. Discharge management includes the surgeon's examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

Survey n:	150	PRE	INTRA	POST						
Response:	30			Day 1	ICU		Hosp. - Other		Office	
Rate %:	20%	RVW	total min		total min	total min	# visits	total min	# visits	total min	# visits
low	6.00		40							
25th%	7.95		90							
med	9.63	35	90	30	0	0	30	2	60	3
75th%	11.47		120							
high	22.80		180							

1995 RVW	Global	CPT	Descriptor
7.78	090	14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
9.37	090	14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
7.18	090	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
8.05	090	14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
8.39*		15500	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on trunk (deleted 1992 and replaced with 15570)</i>
8.59*		15505	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on scalp, arms, or legs (deleted 1992 and replaced with 15572)</i>
8.97*		15510	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on forehead cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet (deleted 1992 and replaced with 15574)</i>
7.85*		15515	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on eyelids, nose, ears, or lips (deleted 1992 and replaced with 15576)</i>
3.75	090	15570	Formation of direct or tubed pedicle, with or without transfer; trunk
3.80	090	15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
3.85	090	15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
4.27	090	15576	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral

*This RVW is based on Harvard Phase 3 crosswalked work values and has been scaled to the 1995 MFS.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT	Data Source (Harvard / 5- Yr)	Time in Minutes			
		Pre-service	Intra-service	Post-service (hospital)	Post-service (office)
14001	Harvard (P3)	49	105	48	63
14021	Harvard (P3)	52	116	54	68
14040	Harvard (P4)	45	92	45	63
14060	Harvard (P3)	21	60	24	66
15500*	Harvard (P3)	64	99	67	69
15505*	Harvard (P3)	61	93	66	67
15510*	Harvard (P3)	51	96	80	66
15515*	Harvard (P3)	51	90	73	67
15570	ASPRS 5-Yr	60	120	65	60
15572	ASPRS 5-Yr	43	105	60	60
15574	ASPRS 5-Yr	60	120	90	53
15576	ASPRS 5-Yr	45	90	45	60

*Codes 15500-15515 were deleted in 1992 and replaced with codes 15570-15576.

(P3) denotes Harvard Phase 3

(P4) denotes Harvard Phase 4, refinement

Codes 15500, 15505, 15510, and 15515 were studied as part of the Harvard Phase 3. The results of the study are presented in the table above. The cross-specialty crosswalk work values for these four codes equated to the 1995-scaled RVWs presented under Key References above. In 1992 these codes were deleted and replaced by 15570-15576, however, the published RVWs were reduced **significantly** from the Harvard study values. The survey data for 15570-15576 confirms the time information gathered in the Harvard Study and emphasizes the undervaluation of these codes.

In addition, the work of 15570, 15572, 15574, and 15576 is comparable to the corresponding adjacent flap codes in the range 14001-14060 (see tables above). These codes, also, have significantly higher RVWs than 15570-15576.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The discussion presented above, that compares the RVWs for 15570, 15572, 15574, and 15576 with the RVWs for similar key reference services, emphasizes the undervaluation of these codes based on time alone. The following RVWs are recommended: [15570; RVW=9.85]; [15572; RVW=9.63]; [15774; RVW=10.50]; [15776; RVW=8.50].

As noted above, with the CPT realignment the values have been arbitrarily reduced. Because of this action, ASPRS has resurveyed these four codes and presents this information. While the numbers of respondents was 30, the RUC should be aware that this family of codes are rarely used and finding ASPRS members who have performed this procedure within the last 12 months was difficult. Review of the survey data with knowledgeable plastic surgeons confirms the relativity of these submitted work values.

The intensity, work and visits of this code have not changed in the last five years.

Public Comments

30-Jun-95

Code: 15572

1995 RVUs: 3.8

Recommended RVUs: 11.00

Ratio:

Long Descriptor: Formation of direct or tubed pedicle, with or without transfer, scalp, arms, or legs

Reference Set (y/n): N

Global Period: 090

Frequency: 583

Impact: 4198

Source: 4

Year: 93

Public Comment Letter: 307

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ASPRS

Societies Wishing to Comment: AAD, AAFPRS, AAO-HNS, AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
15572	68.8	25	6.3	31.3	0	0	6.3	6.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
15572	775	675	-6.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
15572	42	38.1	-2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
15572	dermatology	2.7
	general surgery	20.4
	orthopedic surgery	2.8
	otolaryngology	3.6
	plastic surgery	65.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
15572	171	1.6	MALIGNANT NEOPLASM OF CONNECTIV
	172	3.1	MALIGNANT MELANOMA OF SKIN

Public Comments

30-Jun-95

173	17.2	OTHER MALIGNANT NEOPLASM OF SKIN
216	1.6	BENIGN NEOPLASM OF SKIN
232	1.6	CARCINOMA IN SITU OF SKIN
682	1.6	OTHER CELLULITIS AND ABSCESS
692	1.6	CONTACT DERMATITIS AND OTHER ECZ
941	3.1	BURN OF FACE, HEAD, AND NECK

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
15572							
ASPRS			090		3.80		3.80

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
15572								
ASPRS	3.80	3.80		1.00	1.00	1.00	11.00	307

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
15572								
ASPRS	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
15572									
ASPRS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
15572									
ASPRS				11.00	3.80				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 15574 **Global Period:** 090 **1995 RVW:** 3.85 **Recommended RVW:** 10.50

CPT Descriptor: Formation of direct or tubed pedicle, with or without transfer, forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands or feet.

Source and Summary of Comment to HCFA on this service: An Advisory Panel of surgeons representing the American Society of Plastic and Reconstructive Surgeons, the American Society of Maxillofacial Surgeons, the American Society for Reconstructive Microsurgery, the American Association for Hand Surgery, the American Association of Plastic Surgeons, and the American Society for Aesthetic Plastic Surgery reviewed the RVW relationship for the (Medicare) top ranked surgical codes for plastic and reconstructive surgery. The results of this review found code 15574 to be currently undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 56-year old hunter sustains a gun shot injury to his left hand. He is brought to the hospital and initial debridement, fracture stabilization and temporary wound cover is accomplished with dressing changes. A tailored groin flap is planned for coverage of the dorsal defect. At operation, a random patterned groin flap is elevated. The hand is, again, thoroughly debrided and lavaged, and the groin flap is placed. The abdominal wound is closed by primary advancement of the abdominal skin. The post-operative care is routine until either further delay or separation occurs.

Description of Pre-Service Work:

Pre-service work begins with assessing the patient in the emergency department; taking a history as to the incident; obtaining and reviewing emergency department admission imaging and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include personal and patient preparation and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Description of Intra-Service Work:

At surgery, anesthesia is induced prior to any patient preparation. Therefore, "prepping and draping" occurs as part of the intra-operative work. After intra-operative assessment of the cleanliness of the wound is made and suitability of the wound for coverage established, the dimension of the skin defect are measured and transferred to the ipsilateral groin.

The flap is then incised and elevated at the superficial fascial level. The flap is inset into the defect and sutured into place. Usually, the abdominal wall donor defect can be closed by advancement of local tissue. Occasionally, the defect requires a split-thickness skin graft to close the donor site and this portion of the procedure (CPT 15100) is accomplished prior to inset and suture of the flap. Appropriate antibiotic and antibacterial agents are applied topically and then a specially created dressing is created which maintains the relative positions of the hand, the flap, and the abdominal wall.

Description of Post-Service Work:

Post-service work begins with monitoring patient stabilization and the dressing integrity; communication with the family and other health care professionals (including written and oral reports and orders). Hospital visits and services performed by the surgeon, including monitoring and care of the incision; and the critical positioning and antibiotic and pain medication management. Hospitalization usually requires daily direct examination of the hand and flap for 17 to 21 days until detachment and inset of the flap occurs. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay,

instructions for continuing care, and preparation of discharge records. All post-discharge office visits after detachment are included in the global period for that procedure.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

Survey n:	150	RVW	PRE	INTRA	POST						
Response:	29		total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
Rate %:	19%				total min	# visits	total min	# visits	total min	# visits	
	low	7.18		60							
	25th%	9.00		120							
	med	10.50	50	120	30	0	0	60	4	45	3
	75th%	12.23		180							
	high	19.81		210							

1995 RVW	Global	CPT	Descriptor
7.78	090	14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
9.37	090	14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
7.18	090	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
8.05	090	14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
8.39*		15500	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on trunk (deleted 1992 and replaced with 15570)</i>
8.59*		15505	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on scalp, arms, or legs (deleted 1992 and replace with 15572)</i>
8.97*		15510	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on forehead cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet (deleted 1992 and replaced with 15574)</i>
7.85*		15515	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on eyelids, nose, ears, or lips (deleted 1992 and replaced with 15576)</i>
3.75	090	15570	Formation of direct or tubed pedicle, with or without transfer; trunk
3.80	090	15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
3.85	090	15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
4.27	090	15576	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral

*This RVW is based on Harvard Phase 3 crosswalked work values and has been scaled to the 1995 MFS.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT	Data Source (Harvard / 5- Yr)	Time in Minutes			
		Pre-service	Intra-service	Post-service (hospital)	Post-service (office)
14001	Harvard (P3)	49	105	48	63
14021	Harvard (P3)	52	116	54	68
14040	Harvard (P4)	45	92	45	63
14060	Harvard (P3)	21	60	24	66
15500*	Harvard (P3)	64	99	67	69
15505*	Harvard (P3)	61	93	66	67
15510*	Harvard (P3)	51	96	80	66
15515*	Harvard (P3)	51	90	73	67
15570	ASPRS 5-Yr	60	120	65	60
15572	ASPRS 5-Yr	43	105	60	60
15574	ASPRS 5-Yr	60	120	90	53
15576	ASPRS 5-Yr	45	90	45	60

*Codes 15500-15515 were deleted in 1992 and replaced with codes 15570-15576.

(P3) denotes Harvard Phase 3

(P4) denotes Harvard Phase 4, refinement

Codes 15500, 15505, 15510, and 15515 were studied as part of the Harvard Phase 3. The results of the study are presented in the table above. The cross-specialty crosswalk work values for these four codes equated to the 1995-scaled RVWs presented under Key References above. In 1992 these codes were deleted and replaced by 15570-15576, however, the published RVWs were reduced **significantly** from the Harvard study values. The survey data for 15570-15576 confirms the time information gathered in the Harvard Study and emphasizes the undervaluation of these codes.

In addition, the work of 15570, 15572, 15574, and 15576 is comparable to the corresponding adjacent flap codes in the range 14001-14060 (see tables above). These codes, also, have significantly higher RVWs than 15570-15576.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The discussion presented above, that compares the RVWs for 15570, 15572, 15574, and 15576 with the RVWs for similar key reference services, emphasizes the undervaluation of these codes based on time alone. The following RVWs are recommended: [15570; RVW=9.85]; [15572; RVW=9.63]; [15774; RVW=10.50]; [15776; RVW=8.50].

For this code, as for other codes which deal with the formation, movement and application of tubed pedicles, the post-service work is more intense in time commitment because of the prolonged hospital stay until detachment and inset can occur.

As noted above, with the CPT realignment the values have been arbitrarily reduced. Because of this action, ASPRS has resurveyed these four codes and presents this information. It is acknowledged that the numbers of respondents are less than 30, but the RUC should be aware that this family of codes are rarely used and finding ASPRS members who have performed this procedure within the last 12 months was difficult. Review of the survey data with knowledgeable plastic surgeons confirms the relativity of these submitted work values.

The intensity, work and visits of this code have not changed in the last five years.

Public Comments

30-Jun-95

Code: 15574

1995 RVUs: 3.85

Recommended RVUs: 9.00

Ratio:

Long Descriptor: Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 2,660 **Impact:** 13699

Source: 4 **Year:** 93 **Public Comment Letter:** 307

Reference Services:

CMD Comment:

Societies Wishing to Survey: ASPRS

Societies Wishing to Comment: AAD, AAFPRS, AAO-HNS, AOA, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
15574	52.4	11.1	3.2	47.6	4.8	1.6	0	1.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
15574	2904	2874	-0.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
15574	20.2	19.6	-0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
15574	dermatology	17.6
	general surgery	10.2
	group practices	2.8
	ophthalmology	3.2
	otolaryngology	9.7
	plastic surgery	50.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
15574			

Public Comments

30-Jun-95

173	14.7	OTHER MALIGNANT NEOPLASM OF SKIN
195	1.2	MALIGNANT NEOPLASM OF OTHER AND
216	2.8	BENIGN NEOPLASM OF SKIN
738	1.6	OTHER ACQUIRED MUSCULOSKELETAL
873	3.6	OTHER OPEN WOUND OF HEAD
883	1.2	OPEN WOUND OF FINGER(S)
941	2.4	BURN OF FACE, HEAD, AND NECK
V10	1.2	PERSONAL HISTORY OF MALIGNANT NE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
15574							
ASPRS			090		3.85		3.85

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
15574								
ASPRS	3.85	3.85		1.00	1.00	1.00	9.00	307

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
15574								
ASPRS	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
15574									
ASPRS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
15574									
ASPRS				9.00	3.85				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 15576 **Global Period:** 090 **1995 RVW:** 4.27 **Recommended RVW:** 8.50

CPT Descriptor: Formation of direct or tubed pedicle, with or without transfer, eyelids, nose, ears, lips or intra-oral

Source and Summary of Comment to HCFA on this service: An Advisory Panel of surgeons representing the American Society of Plastic and Reconstructive Surgeons, the American Society of Maxillofacial Surgeons, the American Society for Reconstructive Microsurgery, the American Association for Hand Surgery, the American Association of Plastic Surgeons, and the American Society for Aesthetic Plastic Surgery reviewed the RVW relationship for the (Medicare) top ranked surgical codes for plastic and reconstructive surgery. The results of this review found code 15576 to be currently undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 25-year old male sustains a motorcycle accident with loss of the superior and lateral margins of the helical rim of the left ear. The patient is brought to the operating room and the wound is debrided. Dressing care is accomplished with normal saline dressings. At the second operation, a post auricular tube is formed for transfer and reconstruction to the auricle. At operation, a 1.5 cm tubed pedicle is developed in post-auricular skin. The defect from the tube is reconstructed by primary advancement of the post-auricular skin. Post-operative wound care is routine until further delay or transfer of the tubed pedicle.

Description of Pre-Service Work:

Pre-service work begins with assessment of the patient in the emergency department; taking a history as to the incident; obtaining and reviewing emergency department admission imaging and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include personal and patient preparation; supervision of the positioning, prepping, and draping of the patient; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Description of Intra-Service Work:

After satisfactory anesthetic levels are achieved (this procedure can be done under local infiltrative anesthesia or general anesthesia, the wound is again debrided and its suitability for coverage confirmed.

The dimensions of the defect are measured and transferred to the post-auricular skin. The tube is elevated and local skin undermined at the level of the mastoid fascia to provide primary closure of the donor site. The pedicle is then transferred to the defect, inset, and sutured into place. A dry sterile dressing is applied and held in place with a head wrap bandage.

Description of Post-Service Work:

Post-service work begins with monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring and care of the incision; and antibiotic and pain medication management. Discharge management includes instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging, pathology, and laboratory reports, if needed; and antibiotic and pain medication adjustments. The post-operative period does not, however, include division and further inset of the proximal end of the flap, if required.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

	Survey n: Response: Rate %:	150 31 21%	RVW	PRE	INTRA	POST						
				total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
							total min	# visits	total min	# visits	total min	# visits
low	6.28		45									
25th%	8.00		65									
med	8.50	45	90	30	0	0	15	1	60	3		
75th%	9.25		105									
high	16.10		150									

1995 RVW	Global	CPT	Descriptor
7.78	090	14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
9.37	090	14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
7.18	090	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
8.05	090	14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
8.39*		15500	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on trunk (deleted 1992 and replaced with 15570)</i>
8.59*		15505	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on scalp, arms, or legs (deleted 1992 and replace with 15572)</i>
8.97*		15510	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on forehead cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet (deleted 1992 and replaced with 15574)</i>
7.85*		15515	<i>Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on eyelids, nose, ears, or lips (deleted 1992 and replaced with 15576)</i>
3.75	090	15570	Formation of direct or tubed pedicle, with or without transfer; trunk
3.80	090	15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
3.85	090	15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
4.27	090	15576	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral

*This RVW is based on Harvard Phase 3 crosswalked work values and has been scaled to the 1995 MFS.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT	Data Source (Harvard / 5- Yr)	Time in Minutes			
		Pre-service	Intra-service	Post-service (hospital)	Post-service (office)
14001	Harvard (P3)	49	105	48	63
14021	Harvard (P3)	52	116	54	68
14040	Harvard (P4)	45	92	45	63
14060	Harvard (P3)	21	60	24	66
15500*	Harvard (P3)	64	99	67	69
15505*	Harvard (P3)	61	93	66	67
15510*	Harvard (P3)	51	96	80	66
15515*	Harvard (P3)	51	90	73	67
15570	ASPRS 5-Yr	60	120	65	60
15572	ASPRS 5-Yr	43	105	60	60
15574	ASPRS 5-Yr	60	120	90	53
15576	ASPRS 5-Yr	45	90	45	60

*Codes 15500-15515 were deleted in 1992 and replaced with codes 15570-15576.

(P3) denotes Harvard Phase 3

(P4) denotes Harvard Phase 4, refinement

Codes 15500, 15505, 15510, and 15515 were studied as part of the Harvard Phase 3. The results of the study are presented in the table above. The cross-specialty crosswalk work values for these four codes equated to the 1995-scaled RVWs presented under Key References above. In 1992 these codes were deleted and replaced by 15570-15576, however, the published RVWs were reduced **significantly** from the Harvard study values. The survey data for 15570-15576 confirms the time information gathered in the Harvard Study and emphasizes the undervaluation of these codes.

In addition, the work of 15570, 15572, 15574, and 15576 is comparable to the corresponding adjacent flap codes in the range 14001-14060 (see tables above). These codes, also, have significantly higher RVWs than 15570-15576.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The discussion presented above, that compares the RVWs for 15570, 15572, 15574, and 15576 with the RVWs for similar key reference services, emphasizes the undervaluation of these codes based on time alone. The following RVWs are recommended: [15570; RVW=9.85]; [15572; RVW=9.63]; [15774; RVW=10.50]; [15776; RVW=8.50].

As noted above, with the CPT realignment the values have been arbitrarily reduced. Because of this action, ASPRS has resurveyed these four codes and presents this information. While the number of respondents is 31, the RUC should be aware that this family of codes are rarely used and finding ASPRS members who have performed any of these procedures within the last 12 months was difficult. Review of the survey data with knowledgeable plastic surgeons confirms the relativity of these submitted work values.

The intensity, work and value of these codes have not changed in the last five years.

Public Comments

30-Jun-95

Code: 15576

1995 RVUs: 4.27

Recommended RVUs: ?

Ratio:

Long Descriptor: Formation of direct or tubed pedicle, with or without transfer, eyelids, nose, ears, lips, or intraoral

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 3,589 **Impact:**

Source: 4 **Year:** 93 **Public Comment Letter:** 307

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ASPRS

Societies Wishing to Comment: AAD, AAFPRS, AAO-HNS, AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
15576	55.7	11.3	1	32	1	0	0	5.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
15576	4511	3658	-9.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
15576	13.3	11	-1.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
15576	dermatology	11.4
	general surgery	4.3
	ophthalmology	11.2
	otolaryngology	15.2
	plastic surgery	54.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
15576	172	1.3	MALIGNANT MELANOMA OF SKIN
	173	18.8	OTHER MALIGNANT NEOPLASM OF SKIN

Public Comments

30-Jun-95

195	2.1	MALIGNANT NEOPLASM OF OTHER AND
738	1	OTHER ACQUIRED MUSCULOSKELETAL
873	1.8	OTHER OPEN WOUND OF HEAD
V10	1.8	PERSONAL HISTORY OF MALIGNANT NE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
15576							
ASPRS			090	.	4.27	.	4.27

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
15576								
ASPRS	4.27	4.27	.	1.00	1.00	1.00	.	307

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
15576								
ASPRS	090	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
15576									
ASPRS

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
15576									
ASPRS	4.27	.	.	.	.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 15580 **Global Period:** 090 **1995 RVW:** 3.30 **Recommended RVW:** 9.0

CPT Descriptor: Cross finger flap, including free graft to donor site

Source and Summary of Comment to HCFA on this service: An Advisory Panel of surgeons representing the American Society of Plastic and Reconstructive Surgeons, the American Society of Maxillofacial Surgeons, the American Society for Reconstructive Microsurgery, the American Association for Hand Surgery, the American Association of Plastic Surgeons, and the American Society for Aesthetic Plastic Surgery reviewed the RVW relationship for the (Medicare) top ranked surgical codes for plastic and reconstructive surgery. The results of this review found code 15580 to be currently undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 36-year old laborer sustains an avulsion injury of the volar aspect of the middle phalanx of the left index finger in a grinding machine. The profundus tendon is intact and the neurovascular bundles are intact. At operation, a cross finger pedicle flap from the dorsum of the adjacent left middle phalanx is elevated and rotated downward and placed on the volar aspect of the adjacent finger. The donor site defect was reconstructed with a full thickness skin graft harvested from the left groin. Both the pedicle and the skin graft were sewn in place. The post-operative care is routine for that of a split thickness skin graft.

Description of Pre-Service Work:

Pre-service work begins with assessment of the patient in the emergency department; taking a history as to the incident; obtaining and reviewing emergency department admission imaging and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include dressing, scrubbing, and waiting for surgery; supervision of the positioning, prepping, and draping of the patient; and ensuring that appropriate surgical instruments and supplies are present.

Appropriate anesthesia is initiated. This may be local anesthesia, administered by the surgeon and included in the relative work or; on occasion, general anesthesia may be required.

Description of Intra-Service Work:

At operation after thorough debridement and definition of the wound edges, the injured finger and the appropriate adjacent digit are positioned and the flap designed. The flap is elevated at the level of the paratenon and the dorsal draining veins ligated. The dissection is carried to the mid-axial line adjacent to the injured finger, and the cutaneous restraining ligaments divided. The donor site defect is resurfaced with either a split-thickness or full-thickness skin graft, harvested from an appropriately chosen site and applied and immobilized. The flap is inset and sutured in place. Topical antibiotics and sterile dressings are applied to the fingers and to the donor site. The fingers are immobilized in a specially constructed dressing to remove tension from the flap by preventing motion.

Description of Post-Service Work:

Post-service work begins after skin closure. It includes communication with the patient and the family and other health care professionals (including written and oral reports and orders). Discharge management includes instructions for continuing care, and preparation of discharge records. Unique to this service is the care of the skin graft on the donor site for the flap and the donor site for the graft. At approximately 17 days, the patient is returned to the operating room to provide for detachment of the pedicle and inset (CPT Code 13132). Further follow-up falls in the global period of the second operation.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

Survey n:	150	RVW	PRE	INTRA	POST						
Response:	29		total min	total min	Day 1	ICU		Hosp. - Other		Office	
Rate %:	19%				total min	# visits	total min	# visits	total min	# visits	
low	7.15		45								
25th%	7.63		75								
med	9.00	45	90	30	0	0	15	1	60	4	
75th%	9.88		105								
high	12.15		240								

KEY REFERENCE SERVICE(S):1995 RVW Global CPT Descriptor

7.18	090	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
8.30	090	15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less
3.30	090	15580	Cross finger flap, including free graft to donor site

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT	Data Source (Harvard / 5-Yr)	Time in Minutes			
		Pre-service	Intra-service	Post-service (hospital)	Post-service (office)
14040	Harvard (P4)	45	92	45	63
15240	Harvard (P3)	44	99	51	65
15580	Harvard (P3)	51	106	76	67
15580	ASPRS 5-Yr	45	90	45	60

(P3) denotes Harvard Phase 3

(P4) denotes Harvard Phase 4, refinement

CPT 15580 is essentially a combined flap and graft procedure. CPT 14040 and 15240 represent comparable flap and graft procedures in terms of time and intensity.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This code has been typically undervalued as it has failed to take into account the intra-operative service of harvesting and applying a split-thickness skin graft 15240 or 15100 and the ongoing post-operative care of the skin graft and its donor site. In the case of 15240, a separate surgical incision has been made for the harvest of the full-thickness graft. In the case of 15100, management of the split-thickness donor site requires even more work.

Public Comments

30-Jun-95

Code: 15580

1995 RVUs: 3.3

Recommended RVUs: 11.33

Ratio:

Long Descriptor: Cross finger flap, including free graft to donor site

Reference Set (y/n): N

Global Period: 090

Frequency: 104

Impact: 835

Source: 1

Year: 92

Public Comment Letter: 307

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS, ASPRS

Societies Wishing to Comment: AAD, AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
15580	0	0	0	0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
15580	117	106	-4.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
15580	26.5	34	3.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
15580	general surgery	3.8
	orthopedic surgery	28.3
	plastic surgery	60.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
15580	882	8.3	OPEN WOUND OF HAND EXCEPT FINGER
	883	16.7	OPEN WOUND OF FINGER(S)
	886	16.7	TRAUMATIC AMPUTATION OF OTHER FI
	995	8.3	CERTAIN ADVERSE EFFECTS NOT ELSE

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
15580							
ASPRS		090	090	8.54	3.30	0.39	3.30

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
15580								
ASPRS	3.30	3.30	0.39	1.00	1.00	1.00	11.33	307

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
15580								
ASPRS	090	8.54		36	*	106		36

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
15580									
ASPRS	*	1.0	*	10	1.0	*	15	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
15580									
ASPRS	*	15		11.33	3.30	ps	3		0.039

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 15732 **Global Period:** 090 **1995 RVW:** 12.10 **Recommended RVW:** 16.55

CPT Descriptor: Muscle, myocutaneous, or fasciocutaneous flap of head and neck

Source and Summary of Comment to HCFA on this service: An Advisory Panel of surgeons representing the American Society of Plastic and Reconstructive Surgeons, the American Society of Maxillofacial Surgeons, the American Society for Reconstructive Microsurgery, the American Association for Hand Surgery, the American Association of Plastic Surgeons, and the American Society for Aesthetic Plastic Surgery reviewed the RVW relationship for the (Medicare) top ranked surgical codes for plastic and reconstructive surgery. The results of this review found code 15732 to be currently undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 77-year old smoker develops a carcinoma of the palate which is resected, with loss of approximately one-half of the soft and hard palate. This defect is then reconstructed with a temporalis muscle flap. A separate operative approach must be made to harvest the temporalis muscle. A scalp incision is made and the muscle separated from its origins in the temporal fossa. A dissection of the deep temporal artery is made and this vascular pedicle must carefully be preserved. The muscle is then tunneled deep to the zygomatic arch into the oral cavity. The donor site is closed primarily. The muscle flap is inset into the palatal defect, reconstructing the palate unilaterally.

Description of Pre-Service Work:

Pre-service work begins on the day before surgery and includes obtaining and reviewing pre-procedural laboratory and imaging studies; reviewing findings at the prior operation; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include dressing, scrubbing, and waiting for surgery; supervision of the positioning, prepping, and draping of the patient; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Description of Intra-Service Work:

After the ablative part of the procedure has been completed, appropriate measurements of the defect are obtained and planning for the size of the flap is done. An incision is made over the ipsilateral temporalis muscle. Dissection is carried down to the temporal fascia, which is opened widely and the appropriate amount of muscle dissected from the temporal fossa. This muscle is then isolated on the deep temporal artery and its accompanying vein and the surrounding anatomic relationships assessed.

A tunnel is created deep to the zygomatic arch with care not to disturb existing intact arteries and nerves. This tunnel is opened into the oral cavity and enlarged to accommodate the muscle flap. The flap is transposed and the vascular pedicle re-assessed. The flap is inset into the palatal defect and sutured in place.

Because of its anatomic setting, no dressings are appropriate.

Description of Post-Service Work:

Post-service work begins with communication with the family and other health care professionals (including written and oral reports and orders). All hospital visits and services are performed by the surgeon, including monitoring and care of the incision; monitoring, care, and removal of drains, if used; and antibiotic and pain medication management. Discharge day management includes the surgeon's final

examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging, pathology, and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.
 American Academy of Otolaryngology - Head and Neck Surgery, Inc.

Survey n:	200	PRE	INTRA	POST						
Response:	52			total min	total min	Day 1	ICU		Hosp. - Other		Office
Rate %:	26%	RVW	RVW			total min	total min	# visits	total min	# visits
	low	7.56		90						
	25th %	14.00		149						
	med	16.55	60	150	30	20	1	70	5	60 4
	75th %	20.00		187						
	high	35.00		300						

KEY REFERENCE SERVICE(S):

1995 RVW	Global	CPT	Descriptor
12.10	090	15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter, sternocleidomastoid, levator scapulae)
16.52	090	15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15.26	090	15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
10.07	090	15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
Other MPC services:			
16.38	090	27165	Osteotomy, intertrochanteric or subtrochanteric, including fixation and/or cast
16.30	090	42415	Parotidectomy, superficial portion with dissection and preservation of facial nerve

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT	Data Source (Harvard / 5- Yr)	Time in Minutes			
		Pre-service	Intra-service	Post-service (hospital)	Post-service (office)
15732	Harvard (P4)	71*	183	112*	75*
15734	Harvard (P3)	87*	194	136*	68*
15736	Harvard (P3)	69*	174	115*	71*
15738	Harvard (P3)	69*	187	117*	73*
15732	ASPRS 5-Yr	60	150	123	60
15736	ASPRS 5-Yr	60	150	90	60
15738	ASPRS 5-Yr	60	150	120	60

*Predicted time, not surveyed.

(P3) denotes Harvard Phase 3; (P4) denotes Harvard Phase 4, refinement

Based on available service time data and the judgment of the advisory panel, codes 15732-15738 represent an anomaly in the current Medicare fee schedule.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Muscle-skin graft codes 15732, 15736, 15738

When initially reviewing plastic surgery procedures for the 5-year review, the ASPRS identified a rank order problem in the family of muscle-skin graft codes. The 1995 RVWs for these codes are as follows: 15732 (head)=12.10, 15734 (trunk)=16.52, 15736 (arm)=15.26, and 15738 (leg)=10.07.

The ASPRS advisory panel determined that CPT 15734 (Muscle skin-graft, trunk) was appropriately valued on the RUC's Multispecialty Points of Comparison (MPC) table at 16.52 RVW. (Published in the 1995 *Final Rule as "Addendum G -- Reference Set with 1995 Work RVUs."*) CPT 15734 was initially felt to be the most difficult procedure in the family by the panel.

ASPRS felt that CPT 15736 (arm) represented the least difficult procedure, and that 15732 (head) and 15738 (leg) were generally undervalued. Initial Harvard data on service time (predicted in the Harvard study) supported this ranking.

This comparison shows that codes 15732 and 15738, neither of which have ever been refined by HCFA, are undervalued in this family according to original Harvard data. Scaling of Harvard work values to the 1995 MFS for CPT codes 15732 and 15738 produces values of 14.96 RVW and 15.83 RVW respectively. These two codes are consequently undervalued by -19.0% and -36.0% when compared to the current 1995 RVWs of 12.10 for 15732 and 10.07 for 15738. The other two codes in the family have scaled values much closer to the Harvard study data, with percentage differences of only -1.0% for CPT 15734 and -4.0% for CPT 15736. Therefore, a clear rank order problem exists for CPT 15732 and 15738.

Most importantly, CMD comments, distributed to the RUC last February, stated that for CPT 15738; "RVUs for this code are inconsistent with other muscle flaps in this family." The CMDs proposed an RVU of 15.26, and stated that "intra-service intensities for all these codes should be comparable." This comment, obviously, prompted the need for a survey.

To support the CMD comment and establish a valid rank order, ASPRS surveyed 15732, 15736, and 15738. ASPRS used 15734 as an anchor, as it was accepted on the RUC's MPC. Median survey values were as follows: 15732=16.55 RVW, 15736=16.00 RVW, 15738=19.40. After facilitation with RUC Workgroup 6 in July, the following values were proposed: 15732=16.52 RVW, 15736=16.00 RVW, and 15738=16.52 RVW. This final rank order was supported by ASPRS with only 15736 requiring slightly less work.

Note: The value of 12.50 RVW for CPT 15736 (arm) originated from the initial ASPRS public comments only, and should have been removed from the consent calendar at the April RUC meeting since a survey was being conducted. This staff error and other transcription errors in this family's rationale (due to the short time frame between the ASPRS Advisory Panel meeting and the RUC recommendation deadline) have caused undue confusion when discussing these codes within the RUC process. In addition, workgroup reports distributed to the full RUC in August could not provide sufficient detail on the workgroup's facilitation for this family of codes.

Public Comments

30-Jun-95

Code: 15732 **1995 RVUs:** 12.1 **Recommended RVUs:** 14.00 **Ratio:**

Long Descriptor: Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter, sternocleidomastoid, levator scapulae)

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 3,314 **Impact:** 6297

Source: 2 **Year:** 92 **Public Comment Letter:** 307

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAFPRS, AAO-HNS, ASPRS

Societies Wishing to Comment: AOA

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
15732	43.1	11.8	2.6	39.2	11.1	0	0	6.6

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
15732	3178	3506	5

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
15732	58.4	47.7	-5.4

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
15732	general surgery	3
	group practices	2.5
	ophthalmology	15.9
	otolaryngology	25.4
	plastic surgery	50.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
15732	173	11	OTHER MALIGNANT NEOPLASM OF SKIN

Public Comments

30-Jun-95

198	1.3	SECONDARY MALIGNANT NEOPLASM O
216	1.3	BENIGN NEOPLASM OF SKIN
374	1.6	OTHER DISORDERS OF EYELIDS
873	2.3	OTHER OPEN WOUND OF HEAD

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
15732							
ASPRS		090	090	14.91	12.10	0.81	12.10

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
15732								
ASPRS	12.10	12.10	0.81	1.00	1.00	1.00	14.00	307

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
15732								
ASPRS	090	14.91		44	*	183		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
15732									
ASPRS	*	1.0	*	10	5.0	*	15	0.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
15732									
ASPRS	*	15		14.00	12.10	ps	3		0.042

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 15738 **Global Period:** 090 **1995 RVW:** 10.07 **Recommended RVW:** 19.40

CPT Descriptor: Muscle, myocutaneous, or fascio-cutaneous flap; lower extremity

Source and Summary of Comment to HCFA on this service: An Advisory Panel of surgeons representing the American Society of Plastic and Reconstructive Surgeons, the American Society of Maxillofacial Surgeons, the American Society for Reconstructive Microsurgery, the American Association for Hand Surgery, the American Association of Plastic Surgeons, and the American Society for Aesthetic Plastic Surgery reviewed the RVW relationship for the (Medicare) top ranked surgical codes for plastic and reconstructive surgery. The results of this review found code 15738 to be currently undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year old construction worker sustains a crush injury of the lower leg, resulting in an open fracture of the middle 1/3 of the tibia and external soft tissue loss. The patient is seen in the operating room after the orthopedic surgeon has performed an open reduction and internal fixation of the tibia with compression plates and screws. The defect, as visualized, includes not only the fractured tibia without periosteal cover, but also the exposed plates and screws. A muscle flap is chosen for coverage. The incision created by the orthopedic surgeon is extended in order to allow harvesting of the medial soleus muscle flap. This is detached from the Achilles tendon to free its insertion and then dissected up the midline of the pared muscle. The muscle is then transposed into position to provide coverage for the bone and the hardware. The external surface of the muscle where it satisfies the open soft tissue defect is closed with a split thickness skin graft (separate procedure).

Description of Pre-Service Work: Pre-service work on the day prior to surgery. This preparation includes obtaining and reviewing pre-procedural laboratory and imaging studies; communicating with other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include personal and patient preparation; supervision of the positioning, prepping, and draping of the patient; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite. It also includes consulting with the orthopaedic surgeon regarding incisions and being available while the appliances are placed.

Description of Intra-Service Work: The incision created by the orthopedic surgeon is extended in order to allow harvesting of the medial soleus muscle as a flap. This is detached from the Achilles tendon to free its insertion and then dissected up the midline of the paired muscle. The muscle is then transposed into position, inset and sutured in place to provide coverage for the bone and the hardware. The external surface of the muscle is covered with a split thickness skin graft (separate procedure -- CPT Code 15100). An appropriate dressing is applied.

Description of Post-Service Work: Post-service work begins with monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring and care of the incision; monitoring, care, and removal of drains, if used; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging, pathology, and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

Survey n:	150	RVW	PRE	INTRA	POST						
Response:	28		total min	total min	Day 1	ICU		Hosp. - Other		Office	
Rate %:	19%				total min	# visits	total min	# visits	total min	# visits	
low	12.00		60								
25th %	15.00		120								
med	19.40 0	60	150	30	0	0	90	7	60	4	
75th %	20.00		180								
high	30.00		480								

KEY REFERENCE SERVICE(S):1995 RVW Global CPT Descriptor

12.10 090 15732 Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter, sternocleidomastoid, levator scapulae)
 16.52 090 15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk
 15.26 090 15736 Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
 10.07 090 15738 Muscle, myocutaneous, or fasciocutaneous flap; lower extremity

Other MPC services:

16.38 090 27165 Osteotomy, intertrochanteric or subtrochanteric, including fixation and/or cast
 16.30 090 42415 Parotidectomy, superficial portion with dissection and preservation of facial nerve

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT	Data Source (Harvard / 5- Yr)	Time in Minutes			
		Pre-service	Intra-service	Post-service (hospital)	Post-service (office)
15732	Harvard (P4)	71*	183	112*	75*
15734	Harvard (P3)	87*	194	136*	68*
15736	Harvard (P3)	69*	174	115*	71*
15738	Harvard (P3)	69*	187	117*	73*
15732	ASPRS 5-Yr	60	150	123	60
15736	ASPRS 5-Yr	60	150	90	60
15738	ASPRS 5-Yr	60	150	120	60

*Predicted time, not surveyed.

(P3) denotes Harvard Phase 3

(P4) denotes Harvard Phase 4, refinement

Based on available service time data and the judgment of the advisory panel, codes 15732-15738 represent an anomaly in the current Medicare fee schedule.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

See CPT 15732 for muscle-skin graft family rationale.

Public Comments

30-Jun-95

Code: 15738

1995 RVUs: 10.07

Recommended RVUs: 14.50

Ratio:

Long Descriptor: Muscle, myocutaneous, or fasciocutaneous flap; lower extremity

Reference Set (y/n): N

Global Period: 090

Frequency: 3,860

Impact: 17100

Source: 2

Year: 92

Public Comment Letter: 307

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS, ASPRS

Societies Wishing to Comment: AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
15738	45.3	6.9	27.1	49.3	26.6	0	5.9	2.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
15738	4213	4634	4.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
15738	90.2	92.5	1.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
15738	anesthesiology	16.7
	general surgery	7.4
	group practices	2.6
	orthopedic surgery	2.8
	plastic surgery	65.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
15738	707	13	CHRONIC ULCER OF SKIN
	730	1.2	OSTEOMYELITIS, PERIOSTITIS, AND OTH

Public Comments

30-Jun-95

785	2	SYMPTOMS INVOLVING CARDIOVASCUL
878	1.2	OPEN WOUND OF GENITAL ORGANS (EX
879	3.2	OPEN WOUND OF OTHER AND UNSPECIF
890	2.5	OPEN WOUND OF HIP AND THIGH
891	3.4	OPEN WOUND OF KNEE, LEG (EXCEPT T
998	2.2	OTHER COMPLICATIONS OF PROCEDUR

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
15738							
ASPRS		090	090	15.78	10.07	0.64	10.07

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
15738								
ASPRS	10.07	10.07	0.64	1.00	1.00	1.00	14.50	307

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
15738								
ASPRS	090	15.78		44	*	187		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
15738									
ASPRS	*	1.0	*	10	5.0	*	15	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
15738									
ASPRS	*	15		14.50	10.07	ps	3		0.045

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 17106 Global Period: 090 Current RVW: 4.54 Recommended RVW: 4.54

CPT Descriptor: Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm

Source and Summary of Comment to HCFA on this service: CMD recommends 2.27 RVUs, using CPT 17000, 17100 as reference codes. Their rationale for change states, when pre and post-service work are accounted for, the twenty minutes of intra-service work is valued at over 3.5 RVUs, over five times the intensity of the reference procedures. The reduction lowers the intensity to twice that of the reference procedures.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 3 month old baby presents with a rapidly growing, 2.0 x 3.0cm, bright red plaque on the left lower eyelid and cheek. The strawberry hemangioma is beginning to obstruct vision.

Description of Pre-Service Work:

- *Procedural preparation to include preparation of supplies and equipment, such as use of appropriate surgical tray and laser calibration
- *Obtain protective shields and check for shields on patient and staff
- *Necessary instructions to patient and staff
- *Obtain informed consent

Description of Intra-Service Work:

- *Inspect and palpate lesions for size, location, functional risks, depth
- *Administer sterile prep, when appropriate
- *Administer appropriate anesthesia or sedation
- *Laser set to 6.5 J/cm² at a 5.0mm spot at 585 nm and a total of 45 pulses to photocoagulate the entire lesion
- *Monitoring of patient throughout procedure with appropriate equipment

Description of Post-Service Work:

- *Eye protection removed
 - *Monitors immediate post-procedure recovery
 - *Dressing is applied or instructions provided to staff on dressing application
 - *Instruct parent(s) on wound care, functional risks, risk of recurrence, and follow-up
 - *Completion of medical record charting, including dictation of operative report and, if appropriate, communication to referring physician
-

CPT Code: 17106

SURVEY DATA:

Specialty: Dermatology

Sample Size: 158 Response Rate (%): 20% (32) Median RVW: 4.54

25th Percentile RVW: 4.50 75th Percentile RVW: 5.42 Low: 0.70 High: 10.00

Median Pre-Service Time: 20 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 5 High: 45

Median Post-Service Time: Total Time Number of Visits

Office: 15 2

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	11446	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0cm	4.44
2)	11644	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 3.1 to 4.0cm	4.50
3)	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	7.18
4)	17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 - 50.0 sq cm	9.06

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

code	pre-svc	intra-svc	post-svc	me/j	ts/pe	ps
17106	20	20	15	3	4	4
11446	20	30	15	3	4	4
11644	20	25	15	3	4	4

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The survey substantiates our belief that the work value for this code is appropriately valued. The time is appropriately documented. The technical skill is substantial as physicians need to be trained in laser physics and safety as well as calibrate and utilize expensive technology. The judgement and mental effort would be greater for laser than for the excisional procedures. The physician must judge the blood flow through the hemangioma, the density of blood vessels, dermal thickness and location of the lesion, the power settings and wave length of the laser. Stress is substantial because often these patients are children where a cosmetic deformity and scar from poor results of treatment could cause significant emotional distress and affect the child's interactions with schoolmates. Also, a child is often sedated and the physician monitors the patient's vital signs during the procedure while the patient is under sedation. The procedure has not changed substantially over the past five years with the exception of attempts to decrease cost by performing the procedure in a clinic setting. This actually increases the work for the physician since outpatient treatment of hemangiomas may require sedation anesthesia and monitoring which would not be paid under separate code if performed in an office. The low reimbursement for 17000, destruction of benign lesions including laser, does not accurately reflect the work involved in laser treatment of benign vascular proliferative lesions compared with cryosurgery or electrosurgery, the main therapies for this code. The American Academy of Dermatology, the American Society for Dermatologic Surgery, and the Society for Investigative Dermatology have on several occasions tried to remedy this aberrancy in CPT without success.

The CMDs choice of the 17000/17100 CPT codes as reference services for the 17106-8 series does not take into consideration that the physician work of providing the 17106-8 procedures is greater than 5 times that of the 17000/17100 codes with an intensity greater than 1.5 times that of CPT 17000/17100, because of the complexity of calibrating the laser, the interpretation of amount of target chromophore in the lesion and the proximity to adjacent functional structures. Typically, vascular lesions treated with the laser are on the head and neck and a high percentage of cases involve structures of vital function, such as the eyelid, nose and mouth. During the procedure, the physician must not only treat the patient but assures that radiation from the laser does not cause damage to structures of vital function or accidental injury to the physician and his/her staff. The patient is typically sedated, which is not the case with the CMDs chosen reference codes of 17000/17100. Typically the 17106-8 procedures are performed in an office setting; therefore, delivery of anesthesia and monitoring of the patient's vital signs is the responsibility of the treating physician. These procedure codes are typically used for a pediatric population and the infant/child is normally less receptive to the stress of the medical therapy and therefore in need of sedation. Note that the dermatologists did not select these codes as reference services for the procedure codes in question and the global periods are 010 days for the 17000/17100 codes and 090 for the 17106-8 series of codes.

CMD Comments

30-Jun-95

Code: 17106

1995 RVUs: 4.54

Recommended RVUs: 2.27

Ratio: -0.50

Long Descriptor: Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm

Reference Set (y/n): N Global Period: 090 Frequency: 2,313 Impact: -5250.51

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
17106			
	17000 DESTROY BENIGN/PREMAI LESION	0.64	010
	17100 DESTRUCTION OF SKIN LESION	0.53	010

CMD Comment:

When pre and post-service work are accounted for, the twenty minutes of intra-service work is valued at over 3.5 RVUs, over five times the intensity of the reference procedures. The reduction lowers the intensity to twice that of the reference procedures.

Societies Wishing to Survey: AAD

Societies Wishing to Comment: AAFP, AAFPRS, AOA, ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
17106	32.6	4.7	4.8	51.2	7	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
17106	1802	2674	21.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
17106	1.3	0.7	-0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
17106		
	dermatology	69.4
	general/family practice	4.9
	otolaryngology	3.2
	plastic surgery	10.6
	radiology	3.5

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

	ICD9	Pct of Time Used	ICD9 Descriptor
17106			
	216	2.9	BENIGN NEOPLASM OF SKIN
	228	8.1	HEMANGIOMA AND LYMPHANGIOMA, A
	448	6.4	DISEASE OF CAPILLARIES
	692	2.3	CONTACT DERMATITIS AND OTHER ECZ
	695	4.1	ERYTHEMATOUS CONDITIONS
	702	5.8	OTHER DERMATOSES
	704	2.3	DISEASES OF HAIR AND HAIR FOLLICLE
	706	2.3	DISEASES OF SEBACEOUS GLANDS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
17106							
CMD		090	090	1.90	4.54	2.39	4.54

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
17106								
CMD	4.54	4.54	2.39	1.00	1.00	1.00	2.27	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
17106								
CMD	090	1.90		7		20		7

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
17106									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
17106									
CMD		0		2.27	4.54	dm	3		0.050

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 17107 Global Period: 090 Current RVW: 9.06 Recommended RVW: 9.06

CPT Descriptor: Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 - 50.0 sq cm

Source and Summary of Comment to HCFA on this service: CMD recommends 5.06 RVUs, using 17000 and 17100 as reference codes. Their rationale for change states, when pre and post-service work are accounted for, the sixty minutes of intra-service work is valued at over 8 RVUs, over four times the intensity of the reference procedures. The reduction lowers the intensity to twice that of the reference procedures.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey A 3 year-old child presents with a 5.0 x 3.0cm portwine stain-type hemangioma on the left forehead/upper and lower eyelid area. The patient's parents would like this treated nonsurgically and prior to admission in school because it bleeds and becomes infected.:

Description of Pre-Service Work: (see 17106 example)

Description of Intra-Service Work: (see 17106 example) and

*Flashlamp dye laser set at 585 nm with a 5.0mm spot at 7.25 J/cm²
for a total of 130 pulses

Description of Post-Service Work: (see 17106 example)

SURVEY DATA:

Specialty: Dermatology

Sample Size: 158 Response Rate (%): 20% (32) Median RVW: 9.06

25th Percentile RVW: 8.01 75th Percentile RVW: 9.09 Low: 3.00 High: 14.00

Median Pre-Service Time: 20 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 43.75 Low: 9 High: 90

Median Post-Service Time: Total Time Number of Visits

Office: 20 2

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RWV</u>
1)	15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	9.56
2)	14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	8.05
3)	17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	4.54
4)	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	7.18

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

code	pre-svc	intra-svc	post-svc	me/j	ts/pe	ps
17107	20	30	20	4	4	4
15260	15	55	20	4	5	4
14060	15	40	15	3	4	4

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The rationale for this code is the same as for 17106, however, the lesion size is greater therefore the duration of treatment is longer. Lesions measuring 10 to 50 sq cm may take several times what it takes for smaller lesions to treat. In fact, at one extreme for a lesion coded with 17106 that might be 2 to 4 sq cm in diameter compared with a 50 sq cm lesion coded with 17107, the time for treatment may be as much as 10 times greater. Therefore, using averages and only doubling the value of the work is reasonable. Alternative treatments for hemangioma including excision with full thickness skin grafts or adjacent tissue transfer has been performed in the past but is not considered standard care today yet are valued at higher amounts in many cases.

CMD Comments

30-Jun-95

Code: 17107

1995 RVUs: 9.06

Recommended RVUs: 5.06

Ratio: -0.44

Long Descriptor: Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 - 50.0 sq cm

Reference Set (y/n): N Global Period: 090 Frequency: 505 Impact: -2020

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
17107			
	17000 DESTROY BENIGN/PREMAI LESION	0.64	010
	17100 DESTRUCTION OF SKIN LESION	0.53	010

CMD Comment:

When pre and post-service work are accounted for, the sixty minutes of intra-service work is valued at over 8 RVUs, over four times the intensity of the reference procedures. The reduction lowers the intensity to twice that of the reference procedures.

Societies Wishing to Survey: AAD

Societies Wishing to Comment: AAFP, AAFPRS, AOA, ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
17107	26.7	0	0	60	0	0	0	13.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
17107	418	528	12.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
17107	2.6	2.7	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
17107		
	dermatology	67
	group practices	2.3
	otolaryngology	3.8
	plastic surgery	20.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
17107			

CMD Comments

30-Jun-95

173	3.3	OTHER MALIGNANT NEOPLASM OF SKIN
216	1.7	BENIGN NEOPLASM OF SKIN
232	1.7	CARCINOMA IN SITU OF SKIN
238	3.3	NEOPLASM OF UNCERTAIN BEHAVIOR O
448	8.3	DISEASE OF CAPILLARIES
692	1.7	CONTACT DERMATTIS AND OTHER ECZ
709	3.3	OTHER DISORDERS OF SKIN AND SUBCU
757	8.3	CONGENITAL ANOMALIES OF THE INTE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
17107							
CMD		090	090	2.92	9.06	3.10	9.06

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
17107								
CMD	9.06	9.06	3.10	1.00	1.00	1.00	5.06	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
17107								
CMD	090	2.92		12		59		12

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
17107									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
17107									
CMD		0		5.06	9.06	dm	3		0.031

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 17108 Global Period: 090 Current RVW: 13.10 Recommended RVW: 13.10

CPT Descriptor: Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm

Source and Summary of Comment to HCFA on this service: CMD recommends 7.10 RVUs, using 17000 and 17100 as reference codes. Their rationale for change states, when pre and post-service work are accounted for, the ninety minutes of intra-service work is valued at over 12 RVUs, over four times the intensity of the reference procedures. The reduction lowers the intensity to twice that of the reference procedures.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 13 year-old white female with a large portwine stain on her left thigh measuring 10.0 x 15.0 cm presents for evaluation of Klippel-Trenaunay-Weber syndrome and treatment of the hemangioma. The hemangioma occasionally swells and bleeds and is unsightly.

Description of Pre-Service Work: (see 17106 example)

Description of Intra-Service Work: (see 17106 example) and
*Flashlamp dye laser set at 585 nm with a 7.0 mm spot at 8.25 J/cm²
for a total of 460 pulses

Description of Post-Service Work: (see 17106 example)

SURVEY DATA:

Specialty: Dermatology

Sample Size: 158 Response Rate (%): 20% (32) Median RVW: 13.10

25th Percentile RVW: 12.00 75th Percentile RVW: 13.58 Low: 6.00 High: 24.00

Median Pre-Service Time: 20 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 40 75th Percentile Intra-Svc Time: 85 Low: 10 High: 130

Median Post-Service Time: Total Time Number of Visits

Office: 20 2

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	9.56
2)	14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	8.05
3)	17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	9.06
4)	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hand and/or feet; defect 10 sq cm or less	7.18

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

code	pre-svc	intra-svc	post-svc	me/j	ts/pe	ps
17108	20	45	20	4	4	4
15260	15	60	20	4	4	4
14060	15	40	15	4	4	4

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Rationale essentially the same as 17106 again with the issue of size. A work value of 13.10 is approximately three times that of the smallest lesion. However, these lesions can sometimes involve entire extremities or in rare cases involve 60 to 90% of the body surface area. In some cases, the RVW of 13.10 would be substantially low if lesions of this size were treated. There is no good comparison or reference code for lesions of this size since excision and grafting or excision with flaps would be untenable. Excisions of that size would likely put in jeopardy the patient's life.

CMD Comments

30-Jun-95

Code: 17108

1995 RVUs: 13.1

Recommended RVUs: 7.10

Ratio: -0.46

Long Descriptor: Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 252 **Impact:** -1512

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
17108			
	17000 DESTROY BENIGN/PREMAI LESION	0.64	010
	17100 DESTRUCTION OF SKIN LESION	0.53	010

CMD Comment:

When pre and post-service work are accounted for, the ninety minutes of intra-service work is valued at over 12 RVUs, over four times the intensity of the reference procedures. The reduction lowers the intensity to twice that of the reference procedures.

Societies Wishing to Survey: AAD

Societies Wishing to Comment: AAFP, AAFPRS, AOA, ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
17108	50	0	0	75	0	0	0	25

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
17108	227	230	0.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
17108	7.5	0.9	-3.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
17108		
	dermatology	67
	general surgery	4.3
	group practices	2.6
	plastic surgery	22.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
17108			

CMD Comments

30-Jun-95

228	6.3	HEMANGIOMA AND LYMPHANGIOMA, A
459	12.5	OTHER DISORDERS OF CIRCULATORY S
757	6.3	CONGENITAL ANOMALIES OF THE INTE
782	12.5	SYMPTOMS INVOLVING SKIN AND OTHE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
17108							
CMD		090	090	4.01	13.10	3.27	13.10

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
17108								
CMD	13.10	13.10	3.27	1.00	1.00	1.00	7.10	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
17108								
CMD	090	4.01		13		89		13

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
17108									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
17108									
CMD		0		7.10	13.10	dm	3		0.031

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 19120 **Global Period:** 090 **1995 RVW:** 4.84 **Recommended RVW:** 5.66

CPT Descriptor: Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion or nipple lesion (except 19140), male or female, one or more lesions

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 14 general surgeons, with the assistance of Abt Associates, Inc., designed a study that included a survey instrument to effectively measure all aspects of physician work for commonly performed general surgery services. The results of this study found code 19120 to be undervalued at the present time.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

55-year-old female with 0.75 cm stellate density in the upper outer quadrant of the right breast containing microcalcification by mammography. On physical examination, this is palpable 1 cm superior and lateral to the areola. She is taken to the operating room the following day and, under local anesthesia, undergoes excision of this lesion. Frozen section diagnosis is consistent with infiltrating ductal carcinoma.

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made until the time of the procedure. This activity includes obtaining and reviewing previous laboratory and imaging studies, with special attention to mammograms and ultrasounds of the breast and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work:

The incisional site is identified and injected with local anesthetic, with the injection of additional anesthesia as needed during the operation. The skin is incised. The lesion is identified and dissected with instruments and electrocautery. The biopsy specimen is removed, and the surgeon ensures that the proper history is transmitted to the pathologist, along with the specimen. Intra-operative consultation with the pathologist is accomplished, and further excision is performed, as needed. Drains are placed, as appropriate, and the wound is closed in layers.

Description of Post-Service Work:

Post-service work begins after skin closure in the operating room and includes the application of sterile dressings; monitoring the patient's stability; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring and care of the incision; monitoring, maintenance, and removal of all drains, if used; and antibiotic and pain medication management. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure including removal of sutures; ordering and evaluating periodic mammographic, imaging, pathology, and laboratory reports, as needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American College of Surgeons

Sample Size: 175 Response Rate (%): 49 (28%)

	Median	Low	25th pctl	75th pctl	High
RVW:	5.00	3.00	4.00	6.00	10.00
PRE-Service	32				
INTRA-Service	45	25	30	50	70
POST-Service:					
Day of procedure - total time	20				
ICU - total time / # of visits	0	0			
Other hosp. - total time / # of visits	0	0			
Office - total time / # of visits	20	2			

KEY REFERENCE SERVICE(S):

1995 RVW	Global	CPT	Descriptor
6.17	090	49505	Repair initial inguinal hernia, age 5 years or over; reducible

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT	Study	Pre-Service Time	Intra-Service Time	Post-Service Hospital Time	Post-Service Office Time
49505	Harvard 1,2	37	48	34	25
	Harvard 4	30	48	15	20
19120	5-Year Review Survey	32	45	20	40

Both 19120 and 49505 are performed primarily as outpatient procedures under local anesthesia. 19120 often requires immediate preoperative radiographic review. 19120 requires less intra-service time than 49505; however, considerably more face-to-face counseling is necessary for 19120, increasing the post-service office time.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The recommended increase in the RVW (from 4.84 to 5.66) for code 19120 is based on the fact that the patients presenting for this procedure are more complex due to the availability and more frequent use of stereotactic needle biopsies, a new technology that has been developed in the last five years. This technology identifies patients with a higher percentage of malignant diagnoses (60 percent) compared with previous ratios (20 percent). Biopsy-proven malignant lesions require more extensive excision of tissue, which involves more time and work on the part of the surgeon. The decrease in frequency for this procedure between 1992 and 1994 most likely reflects the fact that surgeons are doing fewer "simple" biopsies and instead are seeing primarily those patients having a high risk of malignancy that have been identified through the new stereotactic needle biopsy technology.

The response to survey question 4b indicated that patients requiring this service are "more complex (more work)." In this context, "more complex" refers to the fact that the patients require: (1) more pre-service time (to discuss the risks of the procedure and the options that are available to the patient); (2) more intra-service time (waiting for pathology reports, excising more tissue), and (3) post-service time (counseling the patient and family). Moreover, this service may represent only the first stage of the procedure for those patients requiring a second operation. In these cases, the post-service time for counseling is considerably longer than when the diagnosis is benign. Due to the fact that most of the patients who are seen by surgeons today are those who have a biopsy-proven malignancy and that these patients require more work on the part of the surgeon, the RVW that is recommended for this code is greater than the median that was derived from the survey.

The recommendation to increase the RVW for code 19120 to 5.66 also is based on an analysis of the vertical relationship within the family of breast surgery codes (19120 through 19180). In order to achieve a better relationship within this family of codes, reductions in the RVWs for codes 19140, 19160, and 19180 were recommended. These reductions were placed on the five-year review consent calendar.

<u>CPT/Descriptor</u>	<u>1995 RVW</u>	<u>Rec. RVW</u>
19120 Removal of breast lesion	4.84	5.66
19140 Removal of breast tissue-for gynecomastia	4.90	4.85
19160 Removal of breast tissue-partial	6.65	5.74
19180 Removal of breast-simple, complete	8.15	8.09

Public Comments

30-Jun-95

Code: 19120

1995 RVUs: 4.84

Recommended RVUs: 5.66

Ratio:

Long Descriptor: Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion or nipple lesion (except 19140), male or female, one or more lesions

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 87,080 **Impact:** 71406

Source: 4 **Year:** 93 **Public Comment Letter:** 346

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACS

Societies Wishing to Comment: AOA, APSA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
19120	36.8	5.5	9.9	97.1	7.5	0.3	0.4	15.1

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
19120	141496	101934	-15.1

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
19120	13.2	11.1	-1.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
19120	general surgery	88.4
	group practices	2.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
19120	174	5.2	MALIGNANT NEOPLASM OF FEMALE BR
	217	2.2	BENIGN NEOPLASM OF BREAST
	610	4.9	BENIGN MAMMARY DYSPLASIAS
	611	12.5	OTHER DISORDERS OF BREAST

Public Comments

30-Jun-95

793	1.5	NONSPECIFIC ABNORMAL FINDINGS ON
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
19120							
ACS		090	090	4.40	4.84	1.10	4.84

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
19120								
ACS	4.84	4.84	1.10	1.00	1.00	1.00	5.66	346

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
19120								
ACS	090	4.40		23		35		39

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
19120									
ACS		0.5		10	0.5		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
19120									
ACS		15		5.66	4.84	gs	n		0.047

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 19318 **Global Period:** 090 **1995 RVW:** 11.08 **Recommended RVW:** 16.90

CPT Descriptor: Reduction mammoplasty

Source and Summary of Comment to HCFA on this service: A plastic and reconstructive surgeon singularly submitted a request for review of 19318 (public comment HCFA control number 442). He compared the bilateral work value ($16.72 = 11.08 \times 1.5$) of reduction mammoplasty to an orthopaedic, a general surgery, a urology, and a neurosurgical procedure, which he believed to require a similar amount of pre-, intra-, and post-operative time and care and surgical training.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 30-year old female presents with excessively large breasts and symptoms of pain and discomfort in her back and neck. She demonstrates notching of the subcutaneous tissue over both shoulders underneath the normal location of her bra straps. She also described intermittent submammary intertriginous, dermatitis in warm weather. She also indicates the fact that her lifestyle is restricted and she avoids sports that require jogging or running and does not participate in aerobics. She currently wears a 38DD bra and is approximately 15 pounds overweight. At operation, a reduction mammoplasty is performed, utilizing an inferior pedicle technique. Note: Ratings of relative work for this operation are for one breast (unilateral) reduction only.

Description of Pre-Service Work:

Pre-service work begins on the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural laboratory and imaging studies, with special attention to mammograms and ultrasounds of the breast; communicating with other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include personal preparation, patient marking, skin preparation; supervision of the positioning, and draping of the patient; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Description of Intra-Service Work:

After the satisfactory induction of general endotracheal anesthesia, the previously applied markings for surgery (done in the standing position prior to surgery) are scratched on the skin with a needle. Then the final skin preparation and draping is accomplished. It should be noted that the skin markings are critical to ensure proper positioning of the nipple/areolar complex in the completed reduction. The operation commences with deep epithelization of the inferior-based pedicle. Extreme care must be taken to suture an adequate base for the pedicle so the blood supply to the nipple/areola complex is maintained. The medial and lateral triangular wedges of skin, subcutaneous tissue, fat, and breast gland are excised. Hemostasis must be meticulous to prevent excessive blood loss.

The remaining breast skin and gland are undermined to the clavicle and excess gland is removed from this flap to provide a uniformly thin flap.

The medial and lateral segments are approximated and the closure completed in layers. The nipple/areolar complex is likewise sutured into place. Drains are placed as indicated.

A bulky dressing, simulating a brassiere, is fabricated and applied over topical antibiotic cream and antiseptic gauze and secured in place.

Description of Post-Service Work:

Post-service work begins after skin closure in the operating room and includes frequent monitoring of the areolar complex to ensure viability; monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring and care of the incision; monitoring, care, and removal of drains, if used; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

Survey n:	150	RVW	PRE	INTRA	POST						
Response:	34		total min	total min	Day 1	ICU		Hosp. - Other		Office	
Rate %:	23%				total min	# visits	total min	# visits	total min	# visits	
low	9.53		90								
25th%	14.27		120								
med	16.90	60	150	30	0	0	20	1	60	4	
75th%	20.00		190								
high	25.00		240								

KEY REFERENCE SERVICE(S):

1995 RVW	Global	CPT	Descriptor
10.07	090	19316	Suspension of breast
31.15	090	19368	Breast reconstruction
15.40	090	30420	Reconstruction of nose

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

There is no other surgical procedure which properly approximates 19318 in complexity on the MPC reference list. 19316 has many of the technical features but typically does not remove any glandular tissue. The intensity and risks (which were noted above average -- 3.73 to 3.50) are perhaps most closely compared to 30420 and 19368 as the final result is so dependent on the careful execution of each step of the procedure.

Although the number of respondents are slightly smaller than we would have expected, the 25th and 75th percentiles are well grouped and all the survey number very consistent.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The significant portions of the work include the criticality of the preparative planning done in the erect position. Once the patient is placed on the operating table and anesthetized, the operating plan cannot be revisited and must not be changed. The need for continuous and meticulous hemostasis and the extensive incisions to be carefully closed are reflected in the operative time.

The survey noted that most respondents felt that the work and intensity were to be ranked at 4 (out of 5). But all agreed that the procedure had not changed significantly in work or site of service in the last 5 years.

Public Comments

30-Jun-95

Code: 19318

1995 RVUs: 11.08

Recommended RVUs: Inc

Ratio:

Long Descriptor: Reduction mammoplasty

Reference Set (y/n): Y

Global Period: 090

Frequency: 1,806

Impact:

Source: 2

Year: 92

Public Comment Letter: 442

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ASPRS

Societies Wishing to Comment: AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
19318	10.6	0	11.3	97	24.2	3	0	12.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
19318	3599	2960	-9.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
19318	67	64.9	-1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
19318	general surgery	3.2
	plastic surgery	92.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
19318	174	4.2	MALIGNANT NEOPLASM OF FEMALE BR
	611	26.5	OTHER DISORDERS OF BREAST
	695	1.5	ERYTHEMATOUS CONDITIONS
	719	3.4	OTHER AND UNSPECIFIED DISORDERS O
	723	4.9	OTHER DISORDERS OF CERVICAL REGIO

Public Comments

30-Jun-95

724	4.2	OTHER AND UNSPECIFIED DISORDERS O
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
19318							
IND			090		11.08		11.08

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
19318								
IND	11.08	11.08		1.00	1.00	1.00	INCR	442

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
19318								
IND	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
19318									
IND									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
19318									
IND				INCR	11.08				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 19350 Global Period: 090 1995 RVW: 8.21 Recommended RVW: 10.00

CPT Descriptor: Nipple / areola reconstruction

Source and Summary of Comment to HCFA on this service: An Advisory Panel of surgeons representing the American Society of Plastic and Reconstructive Surgeons, the American Society of Maxillofacial Surgeons, the American Society for Reconstructive Microsurgery, the American Association for Hand Surgery, the American Association of Plastic Surgeons, and the American Society for Aesthetic Plastic Surgery reviewed the RVW relationship for the (Medicare) top ranked surgical codes for plastic and reconstructive surgery. The results of this review found code 19350 to be currently undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This 46-year old female had a modified radical mastectomy on the right for invasive carcinoma of the right breast. She simultaneously had a transverse rectus abdominous myocutaneous flap reconstruction of the right breast and was now four months post mastectomy and breast reconstruction. The reconstructed breast was quite symmetrical, but lacked a nipple and areola. A nipple and areola graft on the right breast was planned. The patient was measured in the standing position for a location of the nipple and areola on the right breast. Under local anesthesia, a Skate flap was elevated at the site selected for the nipple reconstruction and a full thickness skin graft was taken from the right groin to reconstruct the areola. The right groin donor site was closed primarily.

Description of Pre-Service Work:

Pre-service work begins on the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural laboratory and imaging studies, with special attention to previous history, mammograms and ultrasounds of the breast; communicating with other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include personal and patient preparation; supervision of the positioning, prepping, and draping of the patient; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Description of Intra-Service Work:

The patient is measured in the standing position to ensure even balanced position for a location of the nipple and areola graft on the right breast. Under local anesthesia, a Skate flap is elevated at the site selected for the nipple reconstruction and constructed. A full-thickness skin graft is taken from the right groin to reconstruct the areola. The right groin donor site is closed primarily in layers.

Description of Post-Service Work:

Post-service work consists of communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring and care of the incision. Discharge management includes the surgeon's examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures and care of two operative sites.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

Survey n:	150	RVW	PRE	INTRA	POST						
Response:	27		total min	total min	Day 1	ICU		Hosp. - Other		Office	
Rate %:	18%				total min	# visits	total min	# visits	total min	# visits	
low	3.59			30							
25th%	8.00			86							
med	10.00	45		90	30	0	0	0	0	60 4	
75th%	11.00			106							
high	12.20			150							

KEY REFERENCE SERVICE(S):

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
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7.18	090	14040	Local flap tissue closure - face, hands, genitalia
8.05	090	14060	Local flap tissue closure - nose, eyes, ears
5.43	090	14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
7.46	090	15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The component procedures of 19350 are 14040 (the flap reconstruction) and 15200 full-thickness skin graft).

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

19350 is essentially a combination of 14040 (7.18) and 15200 (7.46). Combining them with the normal 50% reduction would leave approximately 11.00 RVW. The survey respondents had a median of 9.77 which is recommended.

Public Comments

30-Jun-95

Code: 19350

1995 RVUs: 8.21

Recommended RVUs: 10.16

Ratio:

Long Descriptor: Nipple/areola reconstruction

Reference Set (y/n): N

Global Period: 090

Frequency: 575

Impact: 1121

Source: 1

Year: 92

Public Comment Letter: 307

Reference Services:

CMD Comment:

Societies Wishing to Survey:

Societies Wishing to Comment: AOA, ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
19350	0	0	5.9	100	29.4	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
19350	605	732	10

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
19350	29.1	24.3	-2.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
19350	general surgery	6
	group practices	3.6
	plastic surgery	83.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
19350	174	1.5	MALIGNANT NEOPLASM OF FEMALE BR
	610	2.9	BENIGN MAMMARY DYSPLASIAS
	611	20.6	OTHER DISORDERS OF BREAST
	701	2.9	OTHER HYPERTROPHIC AND ATROPHIC

Public Comments

30-Jun-95

V10	5.9	PERSONAL HISTORY OF MALIGNANT NE
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
19350							
ASPRS		090	090	8.52	8.21	0.96	8.21

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
19350								
ASPRS	8.21	8.21	0.96	1.00	1.00	1.00	10.16	307

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
19350								
ASPRS	090	8.52		36		93		30

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
19350									
ASPRS		1.0	*	10	0.0		0	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
19350									
ASPRS		15		10.16	8.21	ps	3		0.057

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW
RUC RECOMMENDATIONS**

Orthopaedic Surgery

Originally, the American Academy of Orthopaedic Surgeons (AAOS) submitted a study conducted by Abt Associates, Inc. of 1,300 orthopaedic services for review during the five-year review. In addition, the AAOS submitted detailed comments on 41 procedures. The Abt study involved a combination of a telephone survey of randomly selected orthopaedic surgeons and multiple consensus panels comprised of orthopaedic subspecialists and generalists. The relative values that resulted from the study were considered by AAOS to be much more appropriately aligned than the Medicare RBRVS. In addition, the AAOS believes that the relative values in the current scale are compressed at both the low and the high end, whereas the Abt values expand the scale in both directions.

In general, AAOS felt that the Harvard RBRVS study underestimated the intra-service work of many of the services its members provide. They are particularly concerned about the fitness-to-rate issue as the relative values for many of the services are based on a survey of general orthopaedic surgeons with little or no experience performing highly specialized services performed by subspecialists within orthopaedic surgery (eg, pediatric orthopaedic surgeons). For example, Harvard included general orthopaedic surgeons in the survey for 28262 *Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity* while AAOS surveyed pediatric orthopaedic surgeons with much more experience performing the procedure. The AAOS survey confirmed that the Harvard study had underestimated intra-service time.

In April, the RUC's Research Subcommittee reviewed the methodology used by Abt and concluded that the RUC should consider a survey of representative codes using RUC methodology to validate the relationship of the Abt-developed relative values to RUC-developed relative values. With HCFA's concurrence, the AAOS elected instead to withdraw the Abt study and the 41 codes, and conduct a RUC survey of the work involved in 83 codes which they felt were misvalued. The AAOS involved 11 national orthopaedic subspecialty organizations in this survey.

The RUC reviewed and is recommending increases for 37 of the 83 codes presented by AAOS. An additional 15 services were reviewed based on comments from the American Academy of Pediatrics (AAP), American Society of Plastic and Reconstructive Surgeons (ASPRS), and Carrier Medical Directors (CMDs). In general, the RUC did not accept recommendations for increased values when the AAOS survey time data was similar to Harvard data or when the reference services cited were not appropriate. The RUC is recommending increased work RVUs to correct rank order anomalies, in codes in which AAOS surveys confirm that the intra-service time for the procedure was underestimated in the Harvard study, and the patient population has changed in the past five years.

The RUC also reviewed and recommends decreases for 10 of the 11 orthopaedic services (CPT codes 25065, 26992, 27000, 27001, 27003, 27006, 27040, 27090, 27265, 27266, 27323, 27550, 64763, 64766) which were identified by a special analysis of trends in claims data and intrawork per unit of time for clinically related groups of services. The description and rationale for these decreases is included in the RUC Report on the entire group of services identified as potentially overvalued.

Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
Replacement or Revision of Major Joint Procedures					
23472	Reconstruct shoulder joint	16.09	16.09	The AAOS survey pre-, intra-, and post-service time is similar to Harvard data for these codes. No compelling evidence presented to increase the RVU.	2
24363	Replace elbow joint	17.66	17.66		2
27134	Revise hip joint replacement	24.54	27.00	<p>The patients requiring these services have become more complex since the Harvard study. The frequency of "repeat" revisions is increasing.</p> <p>Patients undergoing revision of hip joint surgery have poor bone stock, distorted anatomy, require significant time in removing the existing prosthesis, often require supplementary fixation devices and bone grafting, and have significantly higher complication rates as compared to those undergoing first time or primary total hip replacement. Revisions also have a dislocation rate that is three times higher than a primary total hip replacement, which requires careful attention to positioning, rehabilitation, and soft tissue reconstruction.</p> <p>The increment of work between this service and the primary replacement code 27130 <i>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft</i> (RVU = 18.68) is currently inappropriate.</p> <p>A CMD recommended the <u>same</u> increased value (28.47) for <u>both</u> procedures 27134 and 27487 which represents approximately 1.5 times the <u>average</u> of the RVUs for the primary replacement codes (CPT 27130 (18.68) and CPT 27447 (19.69)).</p> <p>The RUC determined that an increase was appropriate but did not agree with the AAOS and CMD recommendation of 28.47. A new value of 27.00 was computed by multiplying the AAOS survey time by the Harvard intensity of work per unit of time (IWPUT).</p>	4

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27137	Revise hip joint replacement	18.67	18.67	The AAOS survey pre-, intra-, and post-service time is similar to Harvard data. No compelling evidence was presented to increase the RVUs. The RUC recommends that the current value be maintained until the AAOS presents further evidence at the February RUC meeting.	2
27138	Revise hip joint replacement	18.93	18.93		2
27487	Revise knee joint replace	21.69	21.69		2
27486	Revise knee joint replace	16.63	18.00	<p>The patients requiring these services have become more complex since the Harvard study. The frequency of "repeat" revisions is increasing.</p> <p>Patients undergoing revision of knee joint surgery have poor bone stock, distorted anatomy, require significant time in removing the existing prosthesis, often require supplementary fixation devices and bone grafting, and have significantly higher complication rates as compared to those undergoing first time or primary total knee replacement. Revisions also have a dislocation rate that is three times higher than a primary total knee replacement, which requires careful attention to positioning.</p> <p>27486 is more similar in work to 27447 <i>Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)</i> (RVU = 19.69).</p> <p>The RUC agreed that this service was undervalued, but did not believe that 27486 should be valued the same as (AAOS Rec = 22.00) 27447.</p>	4
27488	Removal of knee prosthesis	14.48	14.48	The AAOS survey intra-service time is similar to the Harvard data. No other compelling evidence was presented.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
Radical Resection and Tumor Surgery Procedures					
23222	Partial removal of humerus	16.64	22.78	<p>The AAOS survey confirms that the Harvard study did not correctly estimate the intraoperative time for this service. Additionally, the pre-operative work necessary for positioning and marking the patient and preparing materials for prosthetic implant was underestimated.</p> <p>This service is equal to the total work of 23470 <i>Arthroplasty with proximal humeral implant (eg, Neer type operation)</i> (RVU = 16.12) plus the intraoperative work of 23220 <i>Radical resection for tumor, proximal humerus</i> (RVU = 13.31).</p>	1
23920	Amputation at shoulder joint	13.60	13.60	<p>The RUC did not agree that these services are comparable in work to 27295 <i>Disarticulation of hip</i> (RVU = 17.32). No other compelling evidence was presented to increase the current RVU.</p>	2
27049	Remove tumor, hip/pelvis	12.52	12.52		2
27076	Extensive hip surgery	17.93	20.23	<p>The patient population has become more complex. Patients who would have previously had amputations are now eligible for localized tumor resection. As a result, the size of the tumors removed has increased significantly and these larger masses are more difficult to dissect.</p> <p>The AAOS survey intra-service time confirms that the Harvard study did not correctly estimate the intraoperative time of this procedure.</p> <p>New work values were computed by adding an additional amount for intra-service time not captured in the Harvard study.</p>	4
27329	Remove tumor, thigh/knee	11.74	13.00		4
27365	Extensive leg surgery	13.84	15.00		4

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
Foot Reconstruction (other than midtarsal)					
28130	Removal of ankle bone	7.33	7.33	The AAOS survey intra-service was similar to Harvard and there is no other evidence presented to prove that the Harvard survey respondents did not understand that the exposure is included in 28130.	2
28116	Revision of foot	6.17	7.00	<p>A rank order anomaly currently exists between this service and 28122 <i>Partial excision (craterization, surcerization, or diaphysectomy) of bone (eg, for osteomyelitis or tarsal bossing), tarsal or metatarsal bone, except talus or calcaneus (RVU = 6.62)</i>. 28122 requires less intraoperative work in terms of depth and degree of procedure and less time than 28116.</p> <p>The RUC agreed that a rank order anomaly existed, but did not feel the recommended increase (9.00) was appropriate. The RUC recommends that this service be valued between 28122 (6.62) and 28130 (7.33).</p>	4

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
28262	Revision of foot and ankle	12.19	15.00	<p>The Harvard study underestimated intra-service time. Hsiao surveyed general orthopaedic surgeons and this procedure is typically performed by pediatric or foot and ankle orthopaedic surgeons.</p> <p>The patient population for this service has changed in the past 5 years. This procedure is increasingly performed on a younger age group, with the majority of the children under the age of 2. 20-25% of the cases are performed are re-revisions. The risk of iatrogenic harm (compartment syndrome or extremity loss) is high since anomalies in the neurovascular supply of these deformed feet is common.</p> <p>This service is slightly less work than 27165 <i>Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast</i> (RVU = 16.20) and 63017 <i>Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; lumbar</i> (RVU = 16.03).</p>	1
28261	Revision of foot tendon	8.92	10.95	<p>The Harvard survey also significantly undervalued intra-service time for this procedure.</p> <p>28261 is less extensive than 28262 described above. A new RVU was computed to maintain the current proportionality between 28261 and 28262.</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
28309	Incision of metatarsal	8.83	12.00	<p>The AAOS survey confirms that the Harvard study did not correctly estimate pre-, intra-, and post-service time for this service.</p> <p>A rank order anomaly also exists between this service and other orthopaedic codes. This service requires a more extensive surgical dissection and involves more structures (all metatarsals and soft tissue plantar release), and additional incisions than both 28723 <i>Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip</i> (RVU = 10.90) and 28725 <i>Subtalar arthrodesis</i> (RVU = 10.86).</p>	1
27870	Partial removal of hip bone	10.42	13.00	<p>As a result of the 1992 refinement process, an anomaly was created in the family of codes, as 27870 was not revalued along with the other ankle and hind foot arthrodesis codes. The work for this service should be between 28715 <i>Triple arthrodesis</i> (RVU = 12.18) and 28705 <i>Pantalar arthrodesis</i> (RVU = 14.23). The AAOS recommends their survey median of 13.00.</p> <p>The RUC agreed with the AAOS survey and the CMD comment that the work for this service is equal to 27715 <i>Osteoplasty, tibia and fibula, lengthening</i> (RVU = 12.97).</p>	1
28715	Fusion of foot bones	12.18	12.18	<p>The AAOS survey data was comparable to Harvard data. No other compelling evidence was presented. In addition, these services were reviewed and increased in the 1992 refinement process.</p>	2
28705	Fusion of foot bones	14.23	14.23		2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
28750	Fusion of big toe joint	4.77	6.90	<p>The AMPA commented, and the AAOS RVS Advisory Panel agreed, that the work of this service is similar to 28296 <i>Hallux valgus (bunion) correction, with or without sesmoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)</i> (RVU = 8.69).</p> <p>This service requires more work than 26841 <i>Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation</i> (RVU = 6.79) because arthrodesis of the great toe generally requires skeletal fixation. Also postoperative complications associated with the fusion of a weightbearing joint are greater than the carpometacarpal joint of the thumb.</p> <p>The RUC agreed that this service requires more work than 26841, but did not feel that it should be similar to 28296.</p>	4
Foot Reconstruction (midtarsal)					
28730	Fusion of foot bones	9.91	9.91	The RUC did not find the evidence provided to be compelling. In addition, these services were included in the refinement process for the 1993 MFS.	2
28735	Fusion of foot bones	10.07	10.07		2
28737	Revision of foot bones	8.89	8.89		2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
28740	Fusion of foot bones	6.20	7.40	<p>This service is slightly less work than 28725 <i>Subtalar arthrodesis</i> (RVU=10.86) because it involves less exposure and less fusion.</p> <p>The AAOS had recommended a value of 9.95, which the RUC felt was inappropriate. The RUC agreed that the current value does not take into account the intra-service time required to perform the procedure. A new RVU was computed by adding the additional intra-service time in the AAOS survey (22 minutes) multiplied by the IWPUT (0.054).</p> <p>$6.20 + 1.2 (22 \text{ minutes} \times 0.054) = 7.40$</p>	4
Arthrodesis (excluding foot and ankle) Procedures					
27284	Fusion of hip joint	15.62	15.62	The AAOS survey data was very similar to Harvard data. No compelling evidence presented to increase RVU.	2
27286	Fusion of hip joint	15.65	15.65		2

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27580	Fusion of knee	12.26	18.20	<p>This service is the same intraoperative procedure in terms of depth (eg, exposure, bone cuts, intraoperative radiographs to assess alignment, graft/prosthetic implant) and intensity as compared to 27447 <i>Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)</i> (RVU = 19.69) until the point of closure when fixation is performed for 27580 and arthroplasty is performed for 27477. Postoperative care (eg, review of radiographs, monitoring neurovascular recovery) is also similar for both procedures. With 25780 the physician must assess the progress of bone healing on X-ray while with 27447 one must assess range of motion progress.</p> <p>The work of this service has changed in the past five years. In 1990 the majority of patients presenting for this procedure had knee pain or infection, with no loss of bone stock. Today, most patients require this procedure due to failed arthroplasty, with significant bone stock loss.</p> <p>The RUC agreed that this service is undervalued when performed on more complex patients requiring femoral rods. A new value was calculated assuming a frequency of 80% more complex (19.69) and 20% less complex (12.26).</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
23802	Fusion of shoulder joint	14.67	15.62	<p>This service is similar to 27284 <i>Arthrodesis, hip joint (includes obtaining graft)</i> (RVU = 15.62) in terms of degree and depth of intraoperative work.</p> <p>The patient requiring this service has become more complex. New imaging technology has led to an increase in the number of complex patients presenting for this service who are post-traumatic or represent failed total joint with a lot of bone loss, as opposed to patients who are post-infection (not as complex).</p> <p>The AAOS survey median for this service was 19.00. However, the RUC recommends that arthrodesis for the shoulder joint should be valued the same as arthrodesis of the hip joint (code 27284 = 15.62).</p>	4
25810	Fusion/graft of wrist joint	9.79	9.79	<p>The RUC found no compelling evidence to recommend an increase at this time and is recommending the current value as interim. AAOS will have an opportunity to present further evidence at the February 1996 RUC meeting.</p>	2

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
Osteotomy Procedures					
27147	Revision of hip bone	17.58	19.70	<p>The current value for 27147 represents an anomaly in the MFS. Although the time data are similar to 27158 <i>Osteotomy, pelvis, bilateral (for congenital malformation)</i> (rvw = 18.10), the intensity and complexity of work are higher. 27147 requires more work than 27158 because it involves more soft tissue repair, special repair of the capsule, open hip reduction, and includes application of an exacting spica cast. The patients requiring this service generally have a lower tolerance for blood loss, which creates greater intensity intraoperatively.</p> <p>The recommended value is based on a survey median of orthopaedic and pediatric orthopaedic surgeons.</p>	1
27146	Incision of hip bone	13.72	16.55	<p>The current value for 27146 represents an anomaly in the MFS. 27146 is slightly more work than 27165 <i>Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast</i> (rvw = 16.20) as it requires equivalent intra-service time but slightly more pre- and post-service time.</p> <p>The recommended value is based on a survey median of orthopaedic and pediatric orthopaedic surgeons.</p>	1

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27151	Incision of hip bones	18.58	21.50	<p>This service represents the sum of 100% of 27146 <i>Osteotomy, iliac, acetabular or innominate bone</i> (rvu = 16.55) plus the intraoperative work or 27165 <i>Osteotomy, interchanteric or subtrochanteric including internal or external fixation and/or cast</i> (rvu = 16.20). These procedures are performed through separate incisions. Using the multiple procedure rule, the RVU would be 24.65 [16.55 + (16.20 x 50%)].</p> <p>The recommended value is based on a survey median of orthopaedic and pediatric orthopaedic surgeons.</p>	1
27156	Revision of hip bones	20.16	23.62	<p>This service represents the sum of 100% of 27147 <i>Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip</i> (rvu = 19.70) plus the intraoperative work of 27165 <i>Osteotomy, interchanteric or subtrochanteric including internal or external fixation and/or cast</i> (rvu = 16.20). These procedures are performed through separate incisions. Using the multiple procedure rule, the RVU would be 27.80 [19.70 + (16.20 x 50%)].</p> <p>The recommended value is based on a survey median of orthopaedic and pediatric orthopaedic surgeons.</p>	1
27454	Realignment of thigh bone	12.26	16.55	<p>This service is slightly more work than 27165 <i>Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast</i> (rvu = 16.20) because exposure is required and more osteotomies are necessary on the larger femur bone.</p> <p>The RUC lowered the AAOS recommendation of 16.90 to 16.55 because this service is similar in work to 27146 <i>Osteotomy, iliac, acetabular or innominate bone</i> (rvu = 16.55)</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27712	Realignment of lower leg	11.81	13.20	<p>The AAOS argued that this service is more work than 24410 <i>Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)</i> (RVW = 14.28) because a second incision must be made to osteotomize the fibula in order to all correction of the tibia. More osteotomy cuts are frequently necessary since the alignment of the postoperative tibia for proper weight bearing is more critical than 24410.</p> <p>The RUC agreed that the current RVU is inappropriate, but recommends a value of 13.20 based on a review of the median AAOS intra-service times for this service compared to the other codes in this family.</p>	4
Open Treatment of Fractures and Nonunion Procedures					
23615	Repair humerus fracture	8.38	8.38	The AAOS survey failed to prove that the intra-service time in the Harvard study was not accurate. No other compelling evidence was presented.	2
24435	Repair humerus with graft	12.19	12.19		2
25575	Repair fracture radius/ulna	9.47	9.47	HCFA adopted a RUC recommendation for 25575 of 9.99 for the 1993 MFS following the AAOS presentation of the trauma codes to the RUC in June 1992. No compelling evidence was presented that the work has increased since 1993.	2
25628	Repair wrist bone fracture	7.81	7.81	The AAOS survey failed to prove that the intra-service time in the Harvard study was not accurate. No other compelling evidence was presented.	2
27181	Repair slipped epiphysis	13.80	13.80	The AAOS survey failed to prove that the intra-service time in the Harvard study was not accurate. No other compelling evidence was presented.	2

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27227	Treat hip fracture(s)	15.39	22.00	<p>A rank order anomaly currently exists between this service and 27130 <i>Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft</i> (rvu = 18.68).</p> <p>27227 is more intense than 27130 because it involves more complex positioning, more complicated surgical anatomical exposure, and more complexity in terms of fixation and therefore, requires more pre- and post-service time. In contrast to total hip replacement patients, the majority of which are medically, stable, complex acetabular fractures usually occur in severely injured patients who have greater metabolic, nutritional and hemodynamic derangements. Additionally, since many of the acetabular fixations require an extensive intra-pelvic surgical approach or two major incisions, the risk of intraoperative and postoperative complications is far greater than that associated with a total hip replacement.</p>	1

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27228	Treat hip fracture(s)	17.90	25.59	<p>This procedure is the most difficult management problem in the universe of orthopaedic trauma care. 27228 is similar in work to 20816 <i>Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon); complete amputation (rvu = 29.67)</i>. Both procedures require an extraordinary amount of skill and experience to visualize and correct and both have a high risk of postoperative wound complications.</p> <p>The RUC agreed that this service is currently undervalued, but felt that the current relationship between 27227 and 27228 is correct. The RUC, therefore, recommends an RVU of 25.59 for 27228 to maintain this relationship.</p>	4
27513	Treatment of thigh fracture	16.78	16.78	<p>HCFA adopted a RUC recommendations for these codes for the 1993 MFS following the AAOS presentation of the trauma codes to the RUC in June 1992. The RUC did not hear any compelling evidence to increase its previous RUC recommendation.</p>	2
27536	Repair of knee fracture	14.51	14.51		2

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27724	Repair/graft of tibia	12.11	13.88	<p>In comparison to 27758 <i>Open treatment of tibial shaft fracture (with or without fibular fracture) with plate/screws, with or without cerclage</i> (10.51), this service involves a radically more extensive exposure, with debridement of infected tissue when necessary. In the case of malaligned nonunion and malunions, there is extensive bone excision, osteotomy, and realignment. The bone graft in this service is extensively applied to the poster and anterior fibula. Dissection goes in the plane between the calf muscles and interosseous member and the bone graft must be distributed across the surface of the tibia and space between tibia and fibula.</p> <p>The RUC recommends an RVU of 13.88, which is 27758 (10.51) and 50% of 20902 <i>Bone graft, any donor area; major or large</i> (6.74).</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27827	Treat lower leg fracture	9.90	12.95	<p>A recommendation was made to increase the RVU for this service in June 1992. The following selected text presents HCFA's response to this request:</p> <p><u>"Treatment of fractures of weight-bearing articular surface of the tibia (CPT code 27827).</u> The RUC recommended work RVU of 13.5 for code 27827, noting that the work was 34 percent greater than that for code 27822, the treatment of an open trimalleolar ankle fracture. We disagree with this recommendation because we do not agree with the reference service. We set the work RVUs at 8.01, which is comparable to the work RVUs for the open treatment of a trimalleolar fracture (27822), which we view as a service of greater intensity." [Federal Register, Vol. 57, No. 228, November 25, 1992]</p> <p>The decision to use 27822 as a comparable reference service was inappropriate. 27822 can be used as a reference service, however, it is less work than 27827, not more. Surgical treatment is more difficult in 27827 than it is in reference service 27822 because it requires a more complex surgical approach, an exacting reduction involving multiple small bone fragments of the weight bearing surface of the distal tibia and extensive fixation using multiple screws and plates. Pre-and post operative care is more difficult due to the magnitude of bony and soft tissue injury and the increased danger of soft tissue infection, osteomyelitis, and post-traumatic arthritis and joint stiffness.</p> <p>The RUC reaffirms its June 1992 recommendations for these codes minus the budget neutrality adjustment.</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27828	Treat lower leg fracture	12.33	15.12	<p>A recommendation to increase the RVW for 27828 was made in 1992. The following selected text presents HCFA's response to this request:</p> <p><u>Treatment of fracture of weight-bearing articular surface of the tibia (CPT code 27825, 27828).</u> The RUC recommended work RVUs of 15.93 for code 27828 based on a recommendation from AAOS that the work represented 1.57 times the work of code 27822. We do not agree with this comparison and have established work RVUs of 10.40, which are the work RVUs for the open treatment of a billeolar ankle fracture code 27814), which we believe is a better reference service. "[Federal Register, Vol. 57, No. 228, November 25, 1992]</p> <p>The decision to use 27814 as a comparable reference service was inappropriate. CPT codes 27822 <i>Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip</i> (8.39) and 27823 <i>with fixation of posterior lip</i> (10.90) are better reference services because they involve a greater portion of the ankle joint and reflect an injury that is more clinically similar to the injury involved in 27828.</p> <p>The RUC reaffirms its June 1992 recommendations for these codes minus the budget neutrality adjustment.</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
28415	Repair of heel fracture	13.28	15.00	<p>The AAOS survey confirms that the Harvard study estimate of intra-service time is underestimated.</p> <p>This service is a more complex exposure than 27514 <i>Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation</i> (rvu = 15.98).</p> <p>This service was included in the refinement process in 1992. The RUC was convinced that the patient population for this service has become more complex since this time. This service is provided to more complex patients as advances in imaging technology have allowed for a better ability to characterize different patterns of this fracture.</p>	1
28615	Repair foot dislocation	5.12	6.99	<p>28615 requires several incisions to expose the dislocation and perform fixation with screws/wires/plates. Also, more complex joint arrangements add to the intensity. This service is comparable to 27823 <i>Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip</i> (rvu = 10.90).</p> <p>The typical patient in this service undergoes open reduction with internal fixation. The RUC agrees that 11.00 is reasonable for internal fixation. The RUC recommends a blend of RVUs assuming 75% of the patient population receive internal fixation (11.00) and 25% receive external fixation (5.12).</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
Spine					
21610	Partial removal of rib	8.54	13.66	<p>The AAOS survey data confirms that the Harvard study underestimated the intra-service time of this service. The AAOS survey is based on the responses of orthopaedic surgeons who are members of the North American Spine Society and the American Spinal Injury Association, who are familiar with the complexities and intricacies of this procedure.</p> <p>A recommendation to increase the work RVU was made in 1992. The following text presents HCFA's response to this request:</p> <p>"Costotransversectomy (code 21610). The current work RVUs for this procedure are 6.30. The requested work RVUs were 11.46. There was considerable disagreement regarding the work of this service. Because of this disagreement, we considered keeping the current value. However, in light of the fact that the majority of reviewers recommended an increase, we have assigned work RVUs of 9.00 to this procedure. We believe this procedure involves slightly less work than the excision of a cervical rib (code 21615), which has work RVUs of 9.51." [Federal Register, Vol. 57, No. 228, November 25, 1992, pg 55940].</p> <p>The decision to use 21615 as a comparable reference service that involves more work was incorrect. By definition, costotransversectomy includes excision of a rib AND transverse process. A more appropriate reference service is 63064 <i>Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; single segment</i> (rvu = 23.23) which is very similar in work in the approach and exposure. 63064 requires additional intra-service time for decompression of the spinal canal.</p> <p>The RUC computed a new RVU by multiplying the AAOS survey times by the Harvard 3 intensity factors.</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
Knee Ligament Reconstruction and Arthroscopy Procedures					
27428	Reconstruction, knee	10.68	13.28	The current RVU for this service represents an anomaly in the MFS. For this service, the open procedure represents the same amount of total work as the arthroscopically assisted procedure (29888) and, therefore, should have the same work RVU. The similar intraoperative times of the Harvard study for 29888 confirms this rationale.	1
27429	Reconstruction, knee	11.86	14.67	The AAOS survey confirms the argument that Harvard underestimated the intra-service work of the procedure. AAOS argued that the work of 27429 is equal to the work of 29888 <i>Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction</i> (rvu = 13.28) plus the intra-operative work of 27427 <i>Ligamentous reconstruction (augmentation), knee; extra-articular</i> (rvu = 8.68), which is performed through a separate incision. The RUC agreed that this code is undervalued, but developed new values by using 27428 and 29888 as the base at 13.28 and adding an increment for the extra intra-service time and post-service work.	4
29889	Knee arthroscopy/surgery	10.76	14.41	29888 and 29889 were both valued the same in the original Harvard study. Code 29888 was reviewed by HCFA in the 1992 refinement process and increased, however, 29889 was overlooked. This has created an anomaly between the two services. 29889 is actually more intense and technically difficult than 29888. The RUC agreed that this code is undervalued, but developed new values by using 27428 and 29888 as the base at 13.28 and adding an increment for the extra intra-service time and post-service work.	4

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
Miscellaneous Repairs and Soft Tissue Procedure					
23395	Muscle transfer, shoulder/arm	12.42	16.00	The Harvard intra-service time was underestimated as confirmed by the AAOS survey. The intra-service work and time of 23395 is greater than 23462 <i>Capsulorrhaphy, anterior, any type; with caraciod process transfer</i> (rvw = 14.62) because of mobilization and transfer of a major muscle with its neurovascular pedicle. Additionally, the post-operative care of the patient is greater for 23395 due to the continuing assessment of muscle functioning and neurovascular status and necessary bracing/casting.	1
23420	Repair of shoulder	12.60	12.60	The AAOS survey intra-service time was similar to the Harvard data. No other compelling evidence to increase the current value was presented.	2
23466	Repair shoulder capsule	13.65	13.65	The AAOS survey intra-service time was similar to the Harvard data. No other compelling evidence to increase the current value was presented.	2

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27397	Transplants of thigh tenons	9.33	10.53	<p>The AAOS survey confirms that the intra-service time for this service was underestimated in the Harvard study.</p> <p>27397 is more work than codes 27691 <i>Transfer or transplant of single tenon (with muscle redirection or rerouting); anterior tibial or posterior tibial through interosseous space</i> (9.25) and 27692 <i>Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon combined</i> (1.87).</p> <p>The current RVU for this service represents an anomaly when compared with other services involving similar exposure and tendon transfer/transplant. The recommended increased RVU accurately places the work value for 27397 "relative" to similar procedures in the MFS.</p>	4
27435	Incision of knee joint	8.74	8.74	No compelling evidence to increase the current value was presented.	2
27052	Biopsy of hip joint	5.45	5.45	No compelling evidence to increase the current value was presented. AAOS will have the opportunity to present additional evidence at the February 1996 RUC meeting.	2
Upper Extremity (soft tissue) Procedures					
25107	Remove wrist joint cartilage	5.89	5.89	The AAOS survey intra-service time is similar to Harvard data. No other compelling evidence to increase the current value was presented.	2

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
25115	Remove wrist/forearm lesion	6.26	8.00	<p>A rank order anomaly currently exists between this service and 25116 <i>Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis fungus, Tbc, or other granulomas, rheumatoid arthritis); extnesors, with or without transposition of dorsal retinaculum</i> (rvu = 6.44).</p> <p><i>25260</i> 25620 TK. <i>Repair, tendon or muscle, flexor, forearm and/wrist; primary, single, each tendon or muscle</i> (rvu = 7.33) for ONE tendon requires less intraoperative time and effort than this service which involves NINE tendons that undergo synovectomy. Additionally, if necessary, carpal tunnel release also adds to the intraoperative time and work of 25115. The need to identify and protect the median nerve also adds to the complexity and intensity of this service.</p>	4
26123	Release palm contracture	8.64	8.64	No compelling evidence to increase the current value was presented. Additionally, this service was included in the 1992 refinement process.	2
26442	Release palm & finger tendon	6.10	7.45	<p>The RUC agreed that the intra-service work was underestimated in the Harvard survey. Hand surgeons were not included in the Harvard study.</p> <p>This service is more than 150% of the work of 26440 <i>Tenolysis, simple, flexor tendon; palm OR finger, single, each tendon</i> (4.76) as it requires exposure of the palm AND finger and there is a dramatic amount of adhesion, while there is limited scarring with 26440.</p> <p>The RUC felt that the AAOS survey median of 10.00 was inappropriate and recommends a value of 7.45 which is slightly higher than 150% of 26440.</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
26449	Release forearm/hand tendon	6.39	6.39	No compelling evidence to increase the current value was presented.	2
Nerve Decompression (neuroplasty) Procedures					
29848	Wrist arthroscopy/surgery	4.04	4.04	AAOS argued that this service should be at least equal to 29840 <i>Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)</i> (rvu = 5.39) A very detailed comment letter (489) was submitted by an individual for this service. The individual commenter also argued that this service should be equal to a diagnostic wrist arthroscopy. The RUC did not agree that 29848 is similar in work to 29840. Wrist arthroscopy for carpal tunnel is a more superficial procedure than the diagnostic arthroscopy.	2
64718	Revise ulnar nerve at elbow	5.48	5.48	The AAOS survey intra-service time is similar to Harvard data. No other compelling evidence to increase the current value was presented.	2
64721	Carpal tunnel surgery	3.99	3.99	The AAOS survey intra-service time is similar to Harvard data. No other compelling evidence to increase the current value was presented.	2
Debridement and Biopsy Procedures					
20225	Bone biopsy, trocar/needle	1.87	1.87	No compelling evidence to increase the current value was presented. The current value is similar to the RVU for needle biopsy in other organs.	2

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Code	Descriptor	95 RVU	RUC REC RVU	RUC Rationale	Key
27894	Decompression of leg	7.64	9.13	<p>The proportionality between 27894 and the other two fasciotomy with debridement procedures, 27892 <i>Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve</i> (rvu = 6.10) and 27893 <i>Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve</i> (rvu = 6.06) is currently incorrect. The magnitude of difference in work between 27984 and 27982 or 27893 is greater than the magnitude of difference in work between 27602 and 27600 or 27601. This service is an infrequently performed procedure that is restricted to patients with limb-threatening conditions primarily due to the extensive death of muscle in multiple leg compartments. Necrosis of tissue in multiple compartments of a limb requires complex decision-making about amputation versus limb salvage, and intense interaction with the patient and family to a greater degree than patients requiring 27892 or 27893.</p> <p>The recommended RVU of 9.13 for this service is based on a multiple procedure calculation using the RVUs for codes 27893 and 27892 [6.10 + 50%(6.06) = 9.13].</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
Miscellaneous Orthopaedic Procedures						
24546	Repair humerus fracture	14.66	14.66	Codes 24546-27759 and 29876 and 29882 were identified as undervalued in the Abt study. ASPRS submitted a public comment on codes 29840-29847 stating that these relative values should be increased as wrist arthroscopies are more difficult than larger joint arthroscopies.	The survey results for these codes were within 10% of the current value, therefore, they were withdrawn by AAOS and ASPRS.	2
25420	Repair/graft radius & ulna	15.34	15.34			2
25446	Wrist replacement	15.52	15.52			2
26531	Revise knuckle with implant	7.57	7.57			2
27457	Realignment of Knee	12.60	12.60			2
27506	Repair of thigh fracture	15.93	15.93			2
27607	Treat lower leg bone lesion	7.05	7.05			2
27759	Repair of tibia fracture	12.60	12.60			2
29840	Wrist arthroscopy	5.39	5.39			2
29843	Wrist arthroscopy/surgery	5.86	5.86			2
29844	Wrist arthroscopy/surgery	6.22	6.22			2
29845	Wrist arthroscopy/surgery	7.34	7.34			2
29846	Wrist arthroscopy/surgery	6.60	6.60			2
29847	Wrist arthroscopy/surgery	6.93	6.93			2
29876	Knee arthroscopy/surgery	7.51	7.51			2
29882	Knee arthroscopy/surgery	8.24	8.24	2		

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

26010	Drainage of finger abscess	1.49	1.49	Individual commented that this service may be overvalued as compared to 10060 <i>Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single</i> (rvu = 1.12).	No evidence was presented to decrease the current value. The RUC recommends that drainage of an abscess on the finger is more difficult and should have a higher value than 10060.	2
26356	Repair finger/hand tendon	7.05	7.05	This code was identified as part of the American Society of General Surgeons comment letter which presented the results of their survey using the whipple procedure as a benchmark.	No compelling evidence was presented to increase the current value.	2
27259	Repair of hip dislocation	18.03	20.50	The Harvard survey data was underestimated. These codes are not used for the adult population and the Harvard survey respondents were general orthopaedic surgeons, not pediatric orthopaedic surgeons.	This service is similar in work to 27259 <i>Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening</i> (rvu = 19.70). Both procedures are performed for developmental dysplasia of the hip. The RUC recommends a relative value of 20.50 which is based on a survey median of pediatric orthopaedic surgeons.	1

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

27725	Repair of lower leg	11.04	14.50	These codes were originally submitted by AAOS, but were then withdrawn. AAP conducted a survey and the RUC requests that they be included in the five-year review.	This service is similar in work to 27724 <i>Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)</i> (rvu = 13.88). Both procedures involve the open treatment of tibial nonunions. The RUC recommends a relative value of 14.50 which is based on a survey median of pediatric orthopaedic surgeons.	1 add
28002	Treatment of foot infection	3.76	3.76		No compelling evidence was presented to increase the current value. The AAP will have the opportunity to present additional evidence at the February 1996 RUC meeting.	2 add
28760	Fusion of big toe joint	5.47	7.00	The code is undervalued and is similar to 27418 <i>Anterior tibial tubercleplasty (eg, for chondromalacia patellae)</i> (rvu = 9.82). Complexity is similar in children and adults. The procedure is commonly done in children and less commonly done in adults.	This service is slightly more work than 28750 <i>Arthrodesis, great toe; metatarsophalangeal joint</i> (rvu = 6.90). Both procedures involve great toe joint fusions.	4

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

29700	Removal/revision of cast	0.88	0.57	Removal of casts are usually straightforward, low intensity services. The service should not be valued higher than the application of an Unna boot (code 29580, RVU = .57) or any higher than the application of a Denis-Browne splint (code 29590, RVU = .76).	The RUC agrees with the CMD recommendation.	3
29705	Removal/revision of cast	1.12	0.76	Removals of casts are usually straightforward, low intensity services. The service should not be valued much higher than the application of a Denis-Browne splint (code 29590, RVUs = .76).	The RUC agrees with the CMD recommendation.	3

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27134 Global Period: 090 1995 RVW: 24.54 Recommended RVW: 28.47
Workgroup Recommended New Value: 27.00

CPT Descriptor: Revision of total hip arthroplasty; both components, with or without autograft or allograft

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

Additionally the Medicare Carrier Medical Directors (CMD) submitted a comment that this code is undervalued relative to 27487 in that it has higher intraservice work. [CMD recommendation = 28.47]

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old female, who four years previously, had undergone a THA and has severe pain in the hip secondary to loosening of the acetabular and femoral components, undergoes a revision of the total hip replacement, with replacement of the femoral and acetabular components

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of radiographs and scaled radiographs if necessary which were used for sizing and ordering of special implants or allografts. Review of hip aspiration/arthrogram, and review of preoperative laboratory tests; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes scrubbing; arranging for intraoperative cell saver; positioning the patient; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and implants that are necessary are present and available in the operative suite.

Intraoperative work: The skin incision is made down through subcutaneous tissue, followed by a fascial incision and splitting of the gluteus maximus. Dissection is made through scar tissue to identify the greater trochanter, vastus lateralis. The sciatic nerve is identified. This latter dissection is usually quite tedious and time consuming since the sciatic nerve is at risk. Short external rotators and capsule from posterior intertrochanteric insertions are removed; rotators are tagged and pulled over the sciatic nerve. Joint fluid is taken for culture. The leg length is measured, and wound towels are sewn in. Redundant tissue, fibrocapsular elements inferiorly to hip joint are removed to free up the superior capsule and pseudo capsule. The surgeon then attempts to dislocate the total hip with a bone hook and external rotation. Following this, the proximal vastus lateralis is incised and elevated, and the greater trochanter is osteotomized. The trochanter is retracted anteriorly with vastus lateralis and gluteus medius attached. The anterior capsule and fibrocapsular tissues are then excised. The surgeon then externally rotates the femur with leg over the opposite side of table. The proximal femur is elevated with refractors, and the femoral component is extracted. There is complete capsular and pseudo-capsular debridement, and the femur is packed to prevent bleeding. Following this, the leg is brought back up on to the table and slightly internally rotated. The femur is retracted anteriorly, with debridement of periacetabular reactive tissue and pseudo-capsule. Bone cement around the margins is fragmented. The surgeon drills the center of the cup and extract with acetabular extractor and removes the remainder of the cement. The pseudomembrane is also curetted from all bone defects. Assessment of the degree of bone loss on the acetabular walls is made. Acetabular reaming is done until there is contact on the anterior, posterior walls with absent bone superiorly.

Intraoperative work (continued):

At this point, attention is turned to the allograft. First, the superior pelvic area is prepared for the block allograft. The allograft is obtained from freezer. Soft tissue and articular cartilage are removed from the allograft, and it is fashioned to fit the superior defect. After it has been fashioned the allograft is fixed to the superior acetabulum with lag screws; it is then reamed to match the previously prepared acetabulum. The acetabulum is thoroughly irrigated and debrided. Bone is packed as a grout into the allograft-host junction. The bone cement (polymethylmethacrylate) is mixed and prepared. The acetabulum is irrigated, dried and packed. The cement is applied with pressurization techniques and the acetabulum placed in the proper position. It is important to maintain position and pressure on acetabulum while the cement cures. Extra cement from the acetabular edges is debrided, and the wound is irrigated copiously. At this point, the femur is externally rotated and placed over the side of the table, and the femoral refractors are replaced. The surgeon then manually fragments and removes proximal cement pieces with Moreland revision instruments. The membrane is removed back to the cortical bone. Ultrasound devices are utilized to fragment and remove distal cement mantle. Back cutting of cuffettes and revision instruments to thoroughly remove all cement and reactive membrane from the femoral canal is done. The risk of perforation of the femoral shaft and or fracture is high during this portion of the procedure. Intraoperative X-ray fluoroscopy is frequently used to monitor this cement removal.

The size of the proximal femoral deficiency is assessed, and the allograft for the proximal femur is obtained and thawed. The surgeon elevates the vastus lateralis to expose deficient proximal femoral bone; profundus femoral artery perforating vessels are also identified and ligated. Soft tissue from allograft is removed and the allograft is fashioned to cover the deficient area. The allograft is then applied and fixed with multiple cerclage cables with tensioning devices. The distal femur is reamed with increasing sizes until the cortical bone is adequately engaged, then the proximal femur is reamed with distal centralizing attachment while increasing sizes until adequate proximal bone contact is made with host bone and there is sufficient structural support from the allograft. The trial component is inserted with pre-templated neck length; x-ray is taken to assess position and fit. Leg length and stability are assessed by attaching various length neck/head combinations. The modular implant is then constructed, and the construct is impacted down into the femoral canal. The cerclage cables are further tightened and crimped, and X-rays are taken to evaluate for femoral fractures. The trial reduction is repeated and the appropriate neck/head is selected. The selected femoral head is placed on the implant and the joint is reduced. At this point, stability and range of motion are reassessed. If there is proper fit, the greater trochanter is reattached and fixed with a cable grip system. Bone grafts are placed in the trochanteric area and any residual defects. The area is copiously irrigated, and drains are inserted. The short external rotators and capsular elements are reattached through drill holes in the greater trochanter. The tensor fascia and gluteus maximus fascia are repaired. The subcutaneous tissue is closed; then the skin is closed.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressing and abduction splint. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring lab reports; care and removal of drains and dressings; supervision of physical or occupational therapy; ordering and reviewing postoperative X-rays; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care including home health care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. Great attention to the possibility of postoperative hip dislocation must be given with this procedure by careful supervision of postoperative in-hospital care as well as the direction of physical therapy of postoperative exercise and recovery of activity. The incidence of dislocation is much higher in revision cases than with primary total hips hence the need for critical follow-up and the need to recover hip muscle strength.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; American Association of Hip and Knee Surgeons

Survey n: 178
Response: 43
Rate %: 24%

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
					total min	# visits	total min	# visits	total min	# visits
low	22.00		180							
25th%	25.00		210							
med	28.02	90	240	40	15	1	100	7	60	3
75th%	35.00		270							
high	40.00		360							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27134:	68	238	37	0	0	128	8.5	53	3.5
Harvard 27130: Phase 4	61	128	39	0	0	90	9	35	3.5
Harvard 27487:	64	195	35	0	0	95	9.5	60	4
RUC 27487: (1995)	60	200	30	0	0	80	6	60	4

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
18.68	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft
19.69	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
18.68	090	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft
(21.69/28.47)*	090	27487	Revision of total knee arthroplasty, with or without allograft; all components

*Note: this procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 21.69 to 28.47, is being presented.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The intraoperative time and work for CPT 27134 (*Revision of total hip arthroplasty; both components, with or without autograft or allograft*) is approximately twice the intraoperative time and work of CPT 27130 (*Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft*). Patients undergoing revision of hip joint surgery have poor bone stock, distorted anatomy, require significant time in removing the existing prosthesis, often require supplementary fixation devices and bone grafting, and have significantly higher complication rates as compared to those undergoing first time or primary total hip replacement. Revisions also have dislocation rate that is three times higher than a primary total hip replacement, which requires careful attention to post-operative positioning, rehabilitation, and soft tissue reconstruction.

CPT 27134 involves revision of a "major joint" arthroplasty, with intraoperative work that is comparable to CPT 27487 (*Revision of total knee arthroplasty, with or without allograft; all components*).

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The following points were taken into consideration in determining the recommended new RVW for CPT 27134:

- a. The AMA/RUC survey indicates a higher intraoperative time for revision of total hip compared to revision of total knee, but comparable estimates for complexity/intensity in terms of technical skill & physical effort, mental effort and judgment, and stress. However, the median RVW was less for revision of total hip replacement. [This could be do to the fact that the reference services most often cited were the comparable primary joint replacement procedures (CPT 27130 and CPT 27447), where CPT 27447 (RVW=19.69) has a slightly higher value than CPT 27130 (RVW=18.68). In fact, the survey medians very closely approximate an RVW that is 1.5 times greater than the RVW for each service's comparable primary replacement procedure.]
- b. The Medicare CMDs commented that CPT 27134 (revision of total hip) was undervalued and used CPT 27487 (revision of total knee) as a reference stating that CPT 27134 has higher intraservice work than CPT 27487. They also commented that CPT 27487 (revision of total knee) was undervalued and used CPT 27134 (revision of total hip) as a reference stating they were comparable procedures. In the end, the CMD's recommended the same increased value (28.47) for both procedures that closely approximates 1.5 times the average of the RVWs for the primary replacement codes.

Even though the time estimates consistently show revision of total hip to require more time than revision of total knee, it is the opinion of the Orthopaedic RVS Advisory Panel presenting this recommendation, that the total work for both of these procedures are very comparable, and as such, the Advisory Panel agrees with the CMDs that both procedures should have the same value.

The Advisory Panel chose to conservatively recommend an RVW of 28.47, consistent with the CMDs recommendation. This RVW is conservative because it is lower than the average of the survey median RVWs for CPT 27134 and CPT 27487 ($29.01 = 28.02/2 + 30.00/2$) and it is lower than the average of 1.5 times the value for the comparable primary procedures [$28.78 = (1.5 \times (18.68 + 19.69) / 2)$].

It is also important to point out that patients requiring this service are becoming more complex. The frequency of "repeat" revisions is increasing. With repeat revisions, there is less bone, that is more fragile. Repeat revision patients require larger bone grafts and larger and more complicated prostheses (new technology), which translates into more complex procedures that take more time.

CMD Comments

30-Jun-95

Code: 27134

1995 RVUs: 24.54

Recommended RVUs: 28.47

Ratio: 0.16

Long Descriptor: Revision of total hip arthroplasty, both components, with or without autograft or allograft

Reference Set (y/n): N Global Period: 090 Frequency: 8,822 Impact: 34670.46

Source: 4 Year: 93 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
27134			
	27487 REVISE KNEE JOINT REPLACE	21.69	090

CMD Comment:

27134 has higher intraservice work than 27487

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27134	48.7	7.3	6.9	60.2	12.9	1.2	0.8	10

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27134	9503	9657	0.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27134	96.9	97.5	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27134		
	group practices	2.3
	orthopedic surgery	96.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
27134			
	715	4.5	OSTEOARTHRISIS AND ALLIED DISORD
	718	1.5	OTHER DERANGEMENT OF JOINT
	719	1.9	OTHER AND UNSPECIFIED DISORDERS O

CMD Comments

30-Jun-95

996	18.5	COMPLICATIONS PECULIAR TO CERTAI
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27134							
AAOS		090	090	24.73	24.54	0.99	24.54
CMD		090	090	24.73	24.54	0.99	24.54

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27134								
AAOS	24.54	24.54	0.99	1.00	1.00	1.00	40.19	25
CMD	24.54	24.54	0.99	1.00	1.00	1.00	28.47	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27134								
AAOS	090	24.73		40		238		55
CMD	090	24.73		40		238		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27134									
AAOS		1.0		10	8.5		15	0.0	3.5
CMD		1.0		10	8.5		15	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27134									
AAOS		15		40.19	24.54	or	n		0.074
CMD		15		28.47	24.54	or	n		0.074

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27486 Global Period: 090 1995 RVW: 16.63 Recommended RVW: 22.00
Workgroup Recommended New Value: 18.00
CPT Descriptor: Revision of total knee arthroplasty, with or without allograft; one component

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old female with a painful loose total knee arthroplasty undergoes a total knee revision of one of the components.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of radiographs and scaled radiographs if necessary which were used for sizing and ordering of special implants or allografts. Review of hip aspiration/arthrogram, and review of preoperative laboratory tests; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes scrubbing; arranging for intraoperative cell saver; positioning the patient; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and implants that are necessary are present and available in the operative suite.

Intraoperative work: (The revision of the tibial component is described here. In other revision cases, the femoral component only may be revised.) After the tourniquet is elevated following exsanguination, the old median parapatellar scar utilized to expose the joint. After everting the patella, initially, a synovectomy is performed to expose and visualize the joint. In doing this, tissue is removed that is underlying the implant that had violated the bone and interface. Having completed this and irrigated the joint, attention can be turned to extracting the tibial component. The tibia is cut from its interlock and taken out of the insert. The broken piece is then visualized in back and also then lifted out. The tibial surface is resected, removing bone in order to obtain a stable edge peripherally for supporting the implant. All remaining cement is excised with hand and power tools. The hole is reamed for the central peg. This leaves a sclerotic surface throughout. A right angle bur is then brought in and many small perforations are made in this sclerotic surface for engaging the cement. The entire top surface was previously burred to remove all fibrous tissue. At this point, we irrigate the knee completely, exsanguinate for tourniquet elevation and prepare the remaining bone surfaces using a bur to go over all of the exposed cortical type surfaces to be sure all fibrous tissue have been removed, and then right angle bur to bur small perforation in the sclerotic areas. After a trial reduction, attention is returned to the tibia, removing further bone to flex the bone cut, drop the posterior edge to allow this to seat completely at the top edge of the fibular tibial joint laterally and below that on the medial side but with good coverage and good stability. Components are selected to give complete extension and good tension. Having made all of the decisions, prepared the allograft (as needed) and made all of the cuts for the bone, cementing is begun. The tibia is cemented using pressure inject Simplex-P loaded with Nebcin into the tibial metaphyseal surface but not into the diaphysis and inserting the modular base. The tourniquet is released, hemostasis obtained, deep drain placed, and the wound closed in layers.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressing and extension splint or continuous Passive Motion apparatus (CPM). Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring lab reports; care and removal of drains and dressings (careful inspection of the operative wound is critical since anterior skin slough with secondary infection is a definite complication); supervision of physical or occupational therapy; ordering and reviewing postoperative x-rays; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care including home health care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. Supervising the recovery of range of motion as well as ambulatory status is most important during the postoperative course and involves not only oversight of in-hospital therapy but home care therapy as well.

SURVEY DATA:

Specialty(s): American Academy of Orthopaedic Surgeons; American Association of Hip and Knee Surgeons

Survey n: 178
 Response: 42
 Rate %: 24%

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
					total min	# visits	total min	# visits	total min	# visits
low	18.00		110							
25th%	20.00		125							
med	22.00	60	150	30	0	0	75	6	60	4
75th%	25.00		180							
high	35.00		240							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27486:	53	141	32	0	0	95	9.5	50	5
Harvard 27447: Phase 4	58	139	37	0	0	100	10	60	4

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
18.68	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft
19.69	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
19.69	090	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The intraoperative time and work for CPT 27486 is greater than the intraoperative time and work of CPT 27447 (*Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)*). Patients undergoing revision of knee joint surgery have poor bone stock, distorted anatomy, require significant time in removing the existing prosthesis, often require supplementary fixation devices and bone grafting, and have significantly higher complication rates as compared to those undergoing first time or primary total knee replacement. Revisions also have dislocation rate that is three times higher than a primary total hip replacement, which requires careful attention to positioning.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This recommended RVW brings up the relative value for CPT 27486 so that, in relationship to the recommended RVW for CPT 27487, it approximately corresponds to the current RVW difference between CPT 27486 and CPT 27487:

1995 MFS RVWs: CPT 27486 (16.63); CPT 27487 (21.69)

Recommended RVWs: CPT 27486 (22.00); CPT 27487 (28.47)

It is also important to point out that patients requiring this service are becoming more complex. The frequency of "repeat" revisions is increasing. With repeat revisions, there is less bone, that is more fragile. Repeat revision patients require larger bone grafts and larger and more complicated prostheses (new technology), which translates into more complex procedures that take more time.

Public Comments

05-Jul-95

Code: 27486

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Revision of total knee arthroplasty, with or without allograft; one component

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27486	44.1	3.9	9	52	12.7	0	0	17.5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27486	3555	4064	6.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27486	95	95.4	0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27486	group practices	2.1
	orthopedic surgery	97.2

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27486	AAOS		090	090	15.45	16.63	1.08	16.63

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27486								
AAOS	16.63	16.63	1.08	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27486								
AAOS	090	15.45		30	*	141		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdviedur	Hvis	Svdhvis	Hviedur	Icuvis	Offvis
27486									
AAOS	*	1.0		10	9.5	*	10	0.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
27486									
AAOS	*	10		.	16.63	or	3		0.058

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 23222 Global Period: 090 1995 RVW: 16.64 Recommended RVW: 22.78
Accepted by Worgroup
CPT Descriptor: Radical resection for tumor, proximal humerus; with prosthetic replacement

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old with chondrosarcoma of the proximal humeral metaphysis undergoes a radical enbloc excision of the proximal humerus with replacement with a humeral prosthesis.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing preoperative imaging, pathology, and laboratory studies, with special attention to staging studies that tell the oncologist the local, regional and systemic extent of the tumor. These would include the following studies: MRI of the locally involved area; CT scan of the chest, abdomen, and pelvis; and PET. Preoperative work also includes consulting with the referring physician, if necessary, and other health care professionals; communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent; scrubbing; ordering blood replacement products and appropriate intra-arterial lines necessary for this extensive operation; arranging for intraoperative instrumentation and custom prosthetic constructs that would be appropriate for the patient's situation; careful positioning to allow for necessary local reconstruction. Marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: After an adequate level of general endotracheal anesthesia is induced and the patient has been placed in a semisitting position with the head elevated approximately thirty-five degrees and a bolster placed on the left scapula, a longitudinal incision is made from the region of the distal clavicle down across the deltopectoral groove, staying in the anterolateral portion of the arm. The skin is incised with the knife and the subcutaneous tissue is then spread using Weitlaner refractors and dissected with Metzenbam scissors and tooth forceps. Hemostasis is obtained. The superficial deltoid and biceps fascia is kept with the skin flaps to improve the vascularity. The deltoid muscle and the deltopectoral groove are identified with the cephalic vein. Taking care to leave a small portion of the cephalic vein with the medial portion of the exposure, the deltoid is then carefully subperiosteally elevated off the distal clavicle, acromioclavicular joint and acromion. The deltoid is then dissected down to its insertion on the humerus, resecting as necessary for removal of the tumor. The deltoid insertion is then removed from the humerus subperiosteally and the deltopectoral groove is then developed exposing the underlying rotator cuff and the biceps tendon of the long head. The insertion of the pectoralis major muscle to the humerus is then identified and resected off the humerus, leaving a small attachment close to the main tumor mass. It is tagged and left to retract with the suture tag on it medially. The biceps muscle brachiae long head is then identified in its tendinous portion and cut at its insertion onto the rotator cuff and retracted distally. The exposed shaft of the humerus is then measured and marked. With careful subperiosteal dissection at the mark, using the Cobb elevators, refractors are placed around the bone and a sagittal saw is used to transact the bone at this level.

Intraoperative work (continued)

On immediate transection, bone wax is used to plug the resection line at the specimen side and a curette is used to obtain tissue from the remaining medullary canal. After this is obtained, it is sent for frozen section and immediately plugged with bone wax. After obtaining the frozen section results, the resection proceeds. A bone clamp is placed on the specimen proximally and then with gentle upward retraction, the bone is dissected free of the soft tissue, while keeping a subperiosteal sleeve on the humerus in its entire posterior length. The latissimus dorsi and teres major insertion is identified with a tag suture and cut with the bovie cautery off the humerus, leaving a small tag attached to the specimen. The triceps insertion onto the posterior humerus is then dissected off carefully making sure that the radial nerve is protected at all times. The insertion of the triceps is left attached to the humerus. The dissection continues up medially and the medial rotator cuff is then transected in its attachment to the lesser tuberosity leaving a small cuff of tissue attached to the bone. The inferior glenohumeral ligament is then transected at the joint line and the dissection proceeded around from the medial inferior direction to a lateral superior direction. After the subscapularis is tagged, this is entirely removed with the lesser tuberosity leaving a small insertional cuff of tendon attached to the proximal humerus. The subscapularis tendon is then suture identified, tagged and using bovie cautery is removed off the greater tuberosity leaving a small cuff of tissue still attached to the bone preserving the subperiosteal region. After this is done, the humerus is retracted anteriorly with internal rotation and adduction and the inferospinatus and teres minor insertions onto the posterior aspect of the greater tuberosity are then released, after suture tagging. The remaining portion of the long head of the biceps is cut and the specimen is then sent to pathology. At this point, the entire wound is copiously irrigated with normal saline antibiotic impregnated solution and the attention is then turned towards insertion of the implant.

An appropriately sized proximal humeral prosthetic stem is then opened, along with an appropriately sized head. After reaming the distal humeral canal as necessary with a hand held reamer and a flexible drill bit, the trial prosthesis inside the allograft is inserted. This is then reduced into the glenohumeral joint, assessing the fit. The distal tip of the stem is fashioned for corrected fit. The head is chosen and implanted onto the prosthesis. This is then inserted again into the distal humeral shaft and placed in the proper position, reduced and asses for range of motion. Bone cement is inserted into a well lavaged distal humeral canal with some pressure. The prosthesis is inserted and the markings are aligned to insure proper rotational insertion. After this is done, the prosthesis is reduced and the rotator cuff is attached to the proximal prosthesis.

Next, attention is turned towards reattaching the pectoralis major, deltoid and latissimus dorsi teres insertions. A deep drain is placed and the biceps tendon is then tenodesed to its short head insertion of the coracoid process with #1 Vicryl. The wound is irrigated copiously and a second drain is placed. The deltoid is reapproximated to the acromion and clavicle acromioclavicular joint through the periosteal cuff that is left at the time of deltoid reflection. The superficial deltoid and biceps fascia is closed in interrupted simple fashion and the skin is closed in layers, securing the drains to the skin.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings, any necessary immobilization device (sling and swath). Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring of drainage from indwelling catheters as well as neurologic function of extremity; care and removal of drains; adjustments of immobilization sling and swath as permitted by patient's comfort and stability; supervision of physiotherapy; ordering and reviewing radiographs to determine position of prosthesis; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and planned physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; assessment of physiotherapy progress; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; American Shoulder and Elbow Surgeons; Musculoskeletal Tumor Society

Survey n:	180	RVW	PRE	INTRA	POST						
Response:	46				total min	total min	Day 1	ICU		Hosp. - Other		Office
Rate %:	26%		total min	# visits			total min	# visits	total min	# visits	total min	# visits
low	18.00			120							
25th%	20.25			200							
med	25.00	80		240	30	0	0	75	5	60	4
75th%	30.00			300							
high	59.07			420							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 23222:	61	194	37	0	0	85	8.5	55	5.5
Harvard 23220:	55	146	27	0	0	78	7	59	5
Harvard 23470:	58	113	19	0	0	56	5	59	4

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
18.68	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft
19.69	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
13.31	090	23220	Radical resection for tumor, proximal humerus;
16.12	090	23470	Arthroplasty with proximal humeral implant (eg, Neer type operation)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 23222 (*Radical resection for tumor, proximal humerus; with prosthetic replacement*) is equal to the total work of CPT 23470 (*Arthroplasty with proximal humeral implant (eg, Neer type operation)*) plus the intraoperative work of CPT 23220 (*Radical resection for tumor, proximal humerus*).

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation, and the survey confirms, that the Harvard study did not correctly estimate the intraoperative time for patients requiring CPT 23222. Additionally, the preoperative work necessary for **positioning** and marking the patient and preparing materials for prosthetic implant was underestimated.

CPT 23222 is essentially the combination of CPT 23470 and CPT 23220, and by applying the multiple procedure payment rule, the RVW would equal 22.78 [16.12 + (13.31 x 50%)]. This RVW is recommended, instead of the survey median.

Public Comments

30-Jun-95

Code: 23222

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Radical resection for tumor, proximal humerus; with prosthetic replacement

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
23222	498	32	-74.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
23222	97.4	87.5	-4.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
23222	general/family practice	6.3
	orthopedic surgery	93.8

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
23222							
	AAOS	090	090	16.67	16.64	1.00	16.64

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
23222								
AAOS	16.64	16.64	1.00	1.00	1.00	1.00	35.26	25

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itme	Notett	Imppt
23222								
AAOS	090	16.67		34	*	194		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
23222									
AAOS	*	1.0	*	10	8.5	*	10	0.0	5.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
23222									
AAOS	*	10		35.26	16.64	or	3		0.048

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27076 Global Period: 090 1995 RVW: 17.93 Recommended RVW: 30.00
Worgroup Recommended New Value: 20.23

CPT Descriptor: Radical resection of tumor or infection; ilium, including acetabulum, both pubic rami, or ischium and acetabulum

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 53-year-old male with a chondrosarcoma of the peri-acetabular area of the pelvis undergoes a radical resection of the ilium, acetabulum, pubic and ischial rami. [Please note that any reconstructive procedures would be reported separately. Therefore, only consider the time and work involved in this radical resection procedure.]

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies, with special attention to X-RAY, MRI, CT and angiograms (these studies could include a CT scan of the chest, abdomen, and pelvis; MRI of the knee and whole involved femur; total body scan and PET Scan. These studies will determine the local extent of the tumor and the extent to which a successful local resection can be accomplished versus an amputation); consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes pre-operative scrubbing; arranging for intra-operative blood; positioning to allow access to pelvis anteriorly and posteriorly; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: The incision extends from the posterosuperior iliac spine along the iliac crest and inguinal ligament to the symphysis pubis. The a vertical limb is made from this incision passing just posterior to the greater trochanter and extending into the upper thigh. The abdominal muscles are detached from the iliac crest and the peritoneum is displaced medially to expose the external iliac vessels. The following are then divided: the inguinal ligament and the inferior epigastric vessels. Detach the inguinal ligament from the pubic tubercle and the rectus abdominis from the pubic crest. Divide the pubis with a saw. The common iliac vessels and femoral nerve are exposed. The iliopsoas is preserved unless involved with tumor. The iliacus muscle is divided at the sacroiliac joint and the adductor muscles from the pubis. The obturator nerve and vessels are divided. The following muscles are divided: sartorius, tensor fascia lata, rectus femoris, gluteus medius and minimus. The hip capsule is opened and the femoral neck is cut with a saw. The gluteus maximus and external rotators are divided. The sacroiliac joint is divided with an osteotome after mobilizing the lumbosacral nerve trunk and retracting it medially. The following are next divided: levator ani muscle, sacrospinous and sacrotuberous ligaments and hamstring origin from the ischial tuberosity. The specimen is removed (entire ilium including acetabulum and femoral head) after releasing the adductor magnus from the ischial ramus. The femoral neck is covered by an adjacent muscle. The wound is closed in layers over drains.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and balance traction may be used or abduction splinting of the hip. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including care and removal of drain; supervision of use of crutches (several months) before a cane is possible); and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Musculoskeletal Tumor Society; American Association of Hip and Knee Surgeons

Survey n:	186	PRE	INTRA	POST							
Response:	38			total min	total min	Day 1 total min	ICU		Hosp. - Other		Office
Rate %:	20%	RVW	RVW				RVW	total min	# visits	total min	# visits
	low	15.00		180							
	25th%	25.00		240							
	med	30.00	85	270	30	30	2	120	8	60	4
	75th%	40.00		350							
	high	54.00		560							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27076:	63	230	36	0	0	125	10	55	5.5
Harvard 49215:	65	172	29	0	0	88	8	38	4
Harvard 27049:	61	205	35	0	0	90	9	55	5.5
RUC 27049: (1995)	90	180	30	0	0	70	5	60	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
18.68	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft
17.32	27295	Disarticulation of hip

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
(12.52/17.32)*	090	27049	Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area
21.05	090	49215	Excision of presacral or sacrococcygeal tumor

*Note: this procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 12.52 to 17.32, is being presented.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27076 (*Radical resection of tumor or infection; ilium, including acetabulum, both pubic rami, or ischium and acetabulum*) is more complex and involves more work and time compared to CPT 27049 (*Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area*), because in addition to soft tissue resection, CPT 27049 also involves bone resection.

CPT 27076 involves more exposure and exploration and includes significantly more work and time (including ICU care) and as compared to CPT 49215 (*Excision of presacral or sacrococcygeal tumor*)

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the Harvard study underestimated the intraoperative time for CPT 27076, as confirmed by the current AMA/RUC survey. The patients requiring this service are becoming more complex. Because of an increase in the survival rate to the point of needing this service, patients are presenting with larger masses that are more difficult to dissect. The point is confirmed by the survey response to question 4b, that indicated patients are becoming more complex (more work).

Calculations that multiply the intraoperative time ratio of (CPT 27076 / CPT 49215) by the RVW for CPT 49215 affirm that a value of 30.00 for this service is reasonable and relative:

Harvard to RUC comparison: $(270/172) \times 21.05 = 33.04$

Harvard to Harvard comparison: $(230/172) \times 21.05 = 28.15$

Public Comments

05-Jul-95

Code: 27076

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Radical resection of tumor or infection; ilium, including acetabulum, both pubic rami, or ischium and acetabulum

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27076	0	0	0	100	0	0	0	0

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
27076	68	53	-11.7

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27076	95.6	88.7	-3.5

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
27076	group practices	3.8
	infectious disease	3.8
	orthopedic surgery	79.2
	plastic surgery	11.3

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27076							
	AAOS	090	090	20.23	17.93	0.89	17.93

Public Comments

05-Jul-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27076								
AAOS	17.93	17.93	0.89	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27076								
AAOS	090	20.23		36	*	230		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27076									
AAOS	*	1.0	*	10	12.5	*	10	0.0	5.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27076									
AAOS	*	10		.	17.93	or	3		0.048

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27329 Global Period: 090 1995 RVW: 11.74 Recommended RVW: 17.32
Worgroup Recommended New Value: 13.00

CPT Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18-year-old male with a rhabdomyosarcoma of the quadriceps muscle undergoes radical enbloc resection of all involved soft tissues. (Report any reconstructive procedures separately using the appropriate codes)

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to studies that may include a CT scan of the chest, abdomen, and pelvis, an MRI of the knee and whole involved femur, a total body scan and PET Scan (these studies will determine the local extent of the tumor and the extent to which a successful local resection can be accomplished versus an amputation); consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes scrubbing; arranging for intraoperative blood, marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: A large previously planned incision is made from the iliac crest along the anterior thigh to well below the knee is made and the dissection proceeds as dictated by the preoperative imaging studies. These are available and used in the operating room. The interval between the tensor fascia lata and saartorius muscles is developed and the rectus femoris tendon identified and dissected from the ilium and anterior hip capsule. The quadriceps muscle is then dissected free medially and laterally taking care not to violate the muscle compartment. The femoral nerve is identified and taken with the entire vastus medialis. The lateral extent of the dissection involves removing the vastus lateralis together with the linea aspera taking care to identify and ligate each segmental vessel. This is the most tedious portion of the dissection. The dissection is then carried distally removing the periosteum with the quadriceps muscle to the level of the patella. Multiple perforating vessels are present laterally as well as the geniculatae vessels distally. The entire specimen is then removed en bloc (vastus medialis, vastus intermedius, vastus lateralis, and rectus femoris muscles) by dividing the quadriceps tendon at the level of the patella. Careful hemostasis is obtained and the wound is inspected for remaining tumor. Frozen sections of the tumor margins of the specimen are often obtained to make sure the entire tumor has been removed. Careful closure of the skin flaps over suction drainage is necessary because of the extent of the dissection and dead space. The skin flaps are approximated or rotated as is necessary. Careful monitoring of blood loss during the procedure is necessary with appropriate blood and fluid replacement.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and an extension splint. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including care and removal of drain; adjustments of splint; supervision of ambulation of the patient with crutches will be necessary as well as bracing since active knee extension after the surgical removal of the anterior muscles); and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Musculoskeletal Tumor Society; American Association of Hip and Knee Surgeons

Survey n:	186	PRE	INTRA	POST							
Response:	35			Day 1 total min	ICU		Hosp. - Other		Office		
Rate %:	19%	RVW	total min		total min	total min	# visits	total min	# visits	total min	# visits
	low	13.23		90							
	25th%	17.49		120							
	med	20.00	60	150	30	0	0	70	5	60	4
	75th%	22.00		180							
	high	38.00		250							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27329:	49	128	30	0	0	35	3.5	45	4.5
Harvard 27295:	68	163	26	0	0	112	8	57	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
19.69	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)
17.32	27295	Disarticulation of hip

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
17.32	090	27295	Disarticulation of hip

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27329 (*Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area*) involves similar work as compared with CPT 27295 (*Disarticulation of hip*).

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the Harvard study underestimated the intraoperative time for CPT 27329, as confirmed by the current AMA/RUC survey. It is the judgment of the Advisory Panel that CPT 27329 and CPT 27295 represent similar procedures, and as such, the RVW for CPT 27295 is being recommended, instead of the higher survey median.

Public Comments

05-Jul-95

Code: 27329

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27329	42.9	14.3	7.1	92.9	0	0	0	0

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
27329	662	726	4.7

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27329	76.6	78.1	0.8

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
27329	general surgery	41.1
	group practices	3.9
	orthopedic surgery	40.6
	plastic surgery	8.4

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27329	AAOS		090	090	11.25	11.74	1.04	11.74

Public Comments05-Jul-95

Harvard Data:

Comm	Mswk93	Mfewk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27329								
AAOS	11.74	11.74	1.04	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27329								
AAOS	090	11.25		29	*	128		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27329									
AAOS	*	1.0	*	10	3.5	*	10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfewk95	Sp	Phase	Twput	Iwput
27329									
AAOS	*	10		.	11.74	or	3		0.051

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27365 Global Period: 090 1995 RVW: 13.84 Recommended RVW: 22.88
Worgroup Recommended New Value: 15.00

CPT Descriptor: Radical resection of tumor, bone, femur or knee

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17-year-old female with osteosarcoma of the distal femur undergoes a radical en bloc excision of the entire distal femur and knee joint. (Report any reconstructive procedures separately using the appropriate codes)

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to staging studies that tell the orthopaedic oncologist the local, regional, and systemic extent of the bone cancer. These studies could include a CT scan of the chest, abdomen, and pelvis; MRI of the knee and whole involved femur; total body scan and PET Scan. These studies will determine the local extent of the tumor and the extent to which a successful local resection can be accomplished versus an amputation. Preoperative work also includes consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Pre-service work also includes pre-operative scrubbing; ordering preoperative appropriate allografts or prosthetic devices needed to accomplish the reconstruction; arranging for intra-operative blood transfusions necessary for the operation; positioning as necessary to allow for the exposure of the entire extremity, marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: Resection is begun with an incision directed down medially over the anterior medial thigh and excising the previous area of the incisional biopsy site that is through the medialis muscle. At this point the fascia is incised and along the line of the incision, and is carried down to the area of the attachment of the patellar tendon to the tibia along with the pes anserinus. The fascia is incised along the incision and careful dissection, both sharply and bluntly, around to the lateral and medial, to the medial intermuscular septum as well as the lateral intermuscular septum is accomplished. A cut above the medial joint line is necessary to obtain a clear margin. The femur proximally is identified and, the femur is divided. With the use of a bone clamp, careful dissection around posteriorly and medially is accomplished to envision the Hunter's canal and the attachment of the adductor muscles, which were then carefully removed. The neurovascular bundle is identified and further dissection of the muscle, leaving a well-marginated cuff of muscle medialis around the tumor, is done and freed both medially and laterally. This is carried down to the joint line. The pes anserinus could be preserved easily and resected off the area of the proximal tibia, where the tibia would be cut with the saw. Careful resection or dissection around posteriorly to identify the neurovascular bundle is accomplished, and the small bleeders were clamped and tied with #2-0 and clamped with metal clips as necessary. This freed up the neurovascular bundle down to the posterior capsule of the tibia, and a saw is then used to divide the tibia within a centimeter of the osteoarticular surface. After this, the lateral dissection is also carried laterally around to the lateral intermuscular septum, and this is divided in careful dissection around posteriorly to the proximal fibula area and tibia area and the specimen is then delivered. Careful measurement, prior to the resection, is accomplished to align the femur with Steinmann pins, and a stem plate using the alignment guide. At this point in time, the tourniquet is let down and hemostasis obtained.

Postoperative work begins after skin closure in the operating room and includes application of cast and bulky dressing (may need special brace). Post-service work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring of the hemodynamics of the salvaged limb; care and removal of drainage tubes; adjustments of brace or cast; supervision of physical therapy; ordering and reviewing x-rays of lower operated limb to allow for best functional results; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Musculoskeletal Tumor Society; American Association of Hip and Knee Surgeons

Survey n:	186	PRE	INTRA	POST							
Response:	39			Day 1 total min	ICU		Hosp. - Other		Office		
Rate %:	21%	RVW	total min		total min	total min	# visits	total min	# visits	total min	# visits
	low	14.50		90							
	25th%	21.11		180							
	med	25.00	75	180	30	0	0	90	6	60	4
	75th%	30.00		240							
	high	46.86		360							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27365:	52	138	33	0	0	70	7	50	5
Harvard 27447: Phase 4	58	139	37	0	0	100	10	60	4

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
18.68	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft
19.69	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)

KEY REFERENCE SERVICE(S):

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
19.69	090	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Compared to CPT 27447 (*Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)*), CPT 27365 (*Radical resection of tumor, bone, femur or knee*) requires more skill and judgment and more intraoperative time for exposure of the tumor and for exploration and protection of neurovascular structures while resecting the tumor and bone(s). Postoperatively, chemotherapy adds to the care of this patient.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the Harvard study did not correctly estimate the intraoperative time for patients requiring CPT 27305. This service correlates well with CPT 27447, so it is reasonable to adjust the RVW to reflect the difference in intraoperative time.

To calculate an RVW for CPT 27365, that is "relative" to the current RVW for CPT 27447, but is adjusted for intraoperative time differences, one would multiply the intra-RVW* for 27447 by the additional intraoperative time ratio necessary for CPT 27365; and add this value to the total RVW for CPT 27447, as follows:

$19.69 \text{ (RVW for CPT 27447)} \times 55\% \text{ (Harvard \% intra-time)} = 10.83 \text{ intra-RVW for 27447}$

$10.83 \times 41\text{min}/139\text{min} = 3.19 \text{ (extra RVW for extra intra-time)}$

$19.69 + 3.19 = 22.88 \text{ (recommended value for 27365)}$

*The **intraoperative** RVW for 27447 is 10.83. This is equal to 55% of the **total** RVW, per Harvard's estimation of intra- vs. pre-/post-operative "work" (not time), as reported in Harvard Phase 3 - Final Report.

Public Comments

Code: 27365

1995 RVUs: 13.84 Recommended RVUs: 22.88 Ratio:

Long Descriptor: Radical resection of tumor, bone, femur or knee

Reference Set (y/n): Global Period: 090 Frequency: Impact:

Source: Year: Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27365	44.4	0	11.1	44.4	11.1	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27365	208	275	15

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27365	93.8	94.9	0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27365	general surgery	8.7
	group practices	5.1
	orthopedic surgery	83.3
	plastic surgery	2.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
27365	170	13.9	MALIGNANT NEOPLASM OF BONE AND
	174	2.8	MALIGNANT NEOPLASM OF FEMALE BR
	198	5.6	SECONDARY MALIGNANT NEOPLASM O

Public Comments

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213	2.8	BENIGN NEOPLASM OF BONE AND ARTI
239	2.8	NEOPLASMS OF UNSPECIFIED NATURE
715	2.8	OSTEOARTHROSIS AND ALLIED DISORD
719	2.8	OTHER AND UNSPECIFIED DISORDERS O
733	5.6	OTHER DISORDERS OF BONE AND CART

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27365							
AAOS		090	090	13.77	13.84	1.01	13.84

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27365								
AAOS	13.84	13.84	1.01	1.00	1.00	1.00	26.44	25

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27365								
AAOS	090	13.77		30	*	138		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27365									
AAOS	*	1.0		10	7.0	*	10	0.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
27365									
AAOS	*	10		26.44	13.84	or	3		0.055

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 28116 Global Period: 090 1995 RVW: 6.17 Recommended RVW: 9.00
Workgroup Recommended New Value: 7.00

CPT Descriptor: Ostectomy, excision of tarsal coalition

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 8-year-old with a painful calcaneo-navicular coalition undergoes resection of the bone bridging the calcaneus and navicular.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging (routine X-rays, special views of the subtalar joint or CT scanning), pathology, and laboratory studies; with special attention to preoperative radiographs, hematologic status; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; arranging for intraoperative radiographic table, pneumatic tourniquet; positioning the patient; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: After a pneumatic tourniquet is placed about the upper thigh and the involved lower leg and foot are prepped and draped free and leg is exsanguinated with an Esmark bandage and the pneumatic tourniquet is inflated to an appropriate pressure, a skin incision is made directly over the sinus tarsi. The extensor tendons are identified and retracted medially. The peroneal tendons and the sural nerve are identified laterally and protected. The origin of the extensor digitorum brevis muscle over the sinus tarsi is identified and mobilized with sharp dissection. The fat within the sinus tarsi is removed with rongeurs. This will allow visualization of the calcaneonavicular coalition. This may need to be confirmed radiographically with either plain radiographs or fluoroscopy. When the area of the coalition has been clearly identified a 1 to 2 cm segment is removed with care not to damage the articular surface of the talonavicular or calcaneocuboid joints. The ostectomy site is smoothed with a rongeur. The raw bone edges may be sealed with bone wax to prevent bleeding that may lead to reformation. Following the ostectomy subtalar joint motion should be significantly improved, if not normal. Absorbable sutures are then used to secure the fascial origin of the extensor digitorum brevis muscle into the created bony defect. Using Keith needles the sutures are passed through the area of the ostectomy and brought out through the medial side of the foot. This allows the extensor digitorum brevis to be pulled into the ostectomy site. This also aids in the preventing reformation of the coalition. The sutures are tied over a padded, plastic button. Once this has been completed, the pneumatic tourniquet is deflated and hemostasis is achieved with electrocoagulation. The wound is irrigated and closed over a Hemovac drain. The subcutaneous tissues and skin are closed in layers. Steri strips are applied to the skin edges.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and short leg splint or cast (split to accommodate post surgical swelling). Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; care and removal of Hemovac drain; adjustments of splint or cast; supervision of physical therapy; ordering and reviewing postoperative radiographs; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures after 14 days with a cast change; evaluation of periodic imaging and laboratory reports, antibiotic and pain medication adjustments; and ordering appropriate orthoses when necessary. Once wound healing has occurred the surgeon orders an appropriate physical therapy program and oversees the recovery of hindfoot motion.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America; American Orthopaedic Foot and Ankle Society

Survey n:	244	RVW	PRE total min	INTRA total min	POST						
Response:	64				Day 1 total min	ICU		Hosp. - Other		Office	
Rate %:	26%					total min	# visits	total min	# visits	total min	# visits
	low	6.30		45							
	25th%	8.00		60							
	med	9.00	60	80	30	0	0	28	2	60	4
	75th%	10.15		90							
	high	13.58		180							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 28116:	39	78	20	0	0	5	0.5	35	3.5
Harvard 28725:	50	89	22	0	0	41	4	50	4
Harvard 28122:	43	51	26	0	0	24	2	46	5
Harvard 28130:	49	82	22	0	0	21	2	47	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
10.86	090	28725 Subtalar arthrodesis
9.80	090	28264 Capsulotomy, midtarsal (Heyman type procedure)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
10.86	090	28725	Subtalar arthrodesis
6.62	090	28122	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis or tarsal bossing), tarsal or metatarsal bone, except talus or calcaneus
(7.33/10.86)*	090	28130	Talectomy (astragalectomy)

*Note: this procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 7.33 to 10.86, is being presented.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 28116 (*Ostectomy, excision of tarsal coalition*) involves the same intraoperative exposure and work effort, and slightly less time, as compared to CPT 28725 (*Subtalar arthrodesis*). Postoperative care of the weightbearing extremity is also similar.

CPT 28122 (*Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis or tarsal bossing), tarsal or metatarsal bone, except talus or calcaneus*) requires less intraoperative work in terms of depth and degree of procedure and less time than CPT 28116. Postoperative care of the weightbearing extremity is similar.

CPT 28116 requires slightly less intraoperative work (intensity) to excise and fuse the involved bone surfaces, as compared to the excision involved with CPT 28130 (*Talectomy (astragalectomy)*). Postoperative care of the weightbearing extremity is similar.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This RVW is lower than the key reference services CPT 28725 and CPT 28130 and higher than CPT 28122 and reflects the similarities and differences in intraoperative time and work, as discussed in the comparison to key references section above.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the Harvard study did not correctly estimate the work (time plus intensity) for this service. The current survey and the judgment of the Advisory Panel equate this service to slightly less intraoperative work than CPT 28725 and CPT 28130 and more intraoperative work than CPT 28122, and, as such, the survey median RVW, is recommended to set an appropriate value for CPT 28116 "relative" to the key reference services.

Public Comments

05-Jul-95

Code: 28116 1995 RVUs: 6.17 Recommended RVUs: Ratio:

Long Descriptor: Osteotomy, excision of tarsal coalition

Reference Set (y/n): Global Period: 090 Frequency: Impact:

Source: Year: Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP, APMA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
28116	0	0	0	50	50	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28116	113	96	-7.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28116	19.5	20.8	0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28116	general surgery	6.3
	orthopedic surgery	16.7
	plastic surgery	4.2
	podiatry	70.8
	thoracic surgery	2.1

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28116							
AAOS		090	090	6.51	6.17	0.95	6.17

Public Comments

05-Jul-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28116								
AAOS	6.17	6.17	0.95	1.00	1.00	1.00		

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
28116								
AAOS	090	6.51		24	*	78		30

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
28116									
AAOS	*	0.5	*	10	0.5	*	10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
28116									
AAOS	*	10			6.17	or	3		0.046

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 28262 Global Period: 090 1995 RVW: 12.19 Recommended RVW: 15.00
Accepted by Workgroup

CPT Descriptor: Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

Additionally, the American Academy of Pediatrics submitted a request for review of 28262 (public comment HCFA control number 347) as an undervalued service. CPT 27165 and 63017 were cited as key references. [AAP recommendation = 16.20]

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 15-month-old child with a resistant club foot undergoes a capsulotomy of the midfoot with tendon lengthening and posteromedial and lateral capsular releases.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of all X-rays, operative plan, lab work; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; arranging for intraoperative X-rays, leg tourniquet, advise as to intraoperative drugs, antibiotics; positioning the patient; applying Webril and tourniquet to leg; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: A standard Turco type incision is often made from the palpable border of the medial navicular cuneiform joint posteriorly just inferior to the medial malleolus and then dead posteriorly ascending up the back of the calf, approximately 1/3 to 1/2 of the way to the knee. The skin is opened using a #15 blade and subcutaneous tissue is dissected using sharp dissecting shears. The posterior portion of the wound is opened and incised first. After dissection of the subcutaneous tissue, the palpable tendo-achilles cord is identified. After circumferential dissection of soft tissue and peritendon fat, the Achilles tendon is localized. The small plantaris tendon is also tenolysed and a small section of the plantaris is sent for specimen. Again, the Achilles tendon itself is localized, isolated and a longitudinal incision is made through the length of the Achilles tendon in the operative field. This incision is approximately 3-4 cm. in length. Tendon lengthening continues in such a fashion that the distal end is brought out medially and the proximal end is brought out laterally and both ends, after complete tenolysis, are then clamped. After this is done, dissection is carried through the sub cutaneous tissues in a distal medial direction, such as to identify the other tendons. The neurovascular bundle is dissected posterior to the medial malleolus and then isolated using a vascular vessel loop. After isolation of the neurovascular bundle and retraction, dissection is still carried out in a distal direction, such that the insertion of the posterior tibial tendon is identified. The retinaculum is then incised over the posterior tibialis tendon and dissection of the soft tissues is carried back up in a proximal direction. The tendon is then lengthened at the most proximal extent of the wound. After lengthening, the end of this is clamped off and retracted out of the wound.

Intraoperative work (continued):

Next, the common digital flexor, as well as the flexor hallucis longus, are identified and the retinaculum over these 2 tendons is opened as well. Dissection then proceeds distally along the tunnel of the flexor digitorum longus to the talonavicular joint. After localization of the talonavicular joint, the capsule is incised, first medially, then anteriorly and posteriorly to open up the joint freely. Next, dissection carries us back distally to the subtalar joint. The subtalar joint is then traced out using blunt dissecting scissors and pickups and the capsule around the medial portion of the talonavicular joint is then incised. Our dissection then carries us again distally. The neurovascular bundle is then reflected in a more anterior and posterior subtalar joint. This joint capsule is then incised, allowing even more freedom in the foot and the deforming forces are being alleviated quickly. The next joint that is released is the posterior ankle joint, which is easily located underneath the Achilles tendon that had been previously reflected. Soft tissue is dissected off using blunt scissors and the joint opened from posterior using sharp dissecting scissors. Next, the flexor hallucis longus tendon is again re-identified and at this point, it appears that there is still a small medial and varus vector force, secondary to the tight flexor hallucis tendon. Hence, this tendon is tenolysed near its insertion. After this is done, it should appear that the foot can come back to a neutrally rotated position. After this is done it appears that the foot has come back to a neutrally rotated position. At this time, a wire is placed posteriorly in the talus and fired in a distal direction in such a manner to catch the navicular joint and reduce the joint in its proper orientation relative to the talar head. After this is done, the X-ray image intensified is moved in briefly and quickly to verify initial reduction of the talonavicular joint. After this is done, a transverse K-wire is fired through the posterior portion of the calcaneus and a small traction bow is applied. After this is done, the wound is irrigated with copious amounts of normal sterile saline and the Achilles tendon is then repaired using #2-0 Dexon suture. There are 3 figure of 8 sutures required. After this is done, soft tissue is closed in the subcutaneous level using #2-0 interrupted Vicryl sutures. After that is done, this skin is closed using #4-0 running subcuticular sutures.

Postoperative work begins after skin closure in the operating room and includes application of dressing, Webril and mold cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring daily entire patient status review with physical exam; antibiotic and pain medication management; lab studies; x-rays as needed. Critical observation of the circulation of the foot is mandatory since local circulation can be compromised due to the extensive nature of the soft tissue dissection and radical change of position and alignment of the foot. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures and cast changes with pin removal; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America; American Orthopaedic Foot and Ankle Society

Survey n:	244	PRE	INTRA	POST						
Response:	60			Day 1 total min	ICU		Hosp. - Other		Office	
Rate %:	25%	RVW	total min		total min	total min	# visits	total min	# visits	total min	# visits
low	11.00		60							
25th%	13.00		120							
med	15.00	60	140	30	0	0	30	2	80	4
75th%	18.00		160							
high	26.00		240							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 28262:	48	104	30	0	0	35	3.5	40	4
Harvard 27165:	55	147	28	0	0	99	9	60	5
Harvard 63017: Phase 4	66	168	10	0	0	70	7	45	3

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
16.20	090	27165 Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
9.80	090	28264 Capsulotomy, midtarsal (Heyman type procedure)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
16.20	090	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
16.03	090	63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; lumbar

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The total work of CPT 27165 (*Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast*) is less than to CPT 28262 (*Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity*) and less than CPT 63017 (*Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; lumbar*).

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the Harvard study did not correctly estimate the intraoperative time for CPT 28262. The current survey, the judgment of the Advisory Panel equate this service to slightly less intraoperative work than CPT 63017 and more intraoperative work than CPT 27165, and, as such, the survey median RVW, is recommended to set an appropriate value for CPT 28262 "relative" to the key reference services.

CPT 28262 is recognized by those surgeons most familiar with this procedure (pediatric and foot and ankle) to require high technical skill, in which great judgment must be exercised during the procedure. The risk of iatrogenic harm (compartment syndrome or extremity loss) is high since anomalies in the neurovascular supply of these deformed feet is common. These surgeons are most "fit-to-rate" the work value, and through the AAOS AMA/RUC survey, they have estimated the work and time of CPT 28262 similar to CPT 63017 and 27165.

Public Comments

30-Jun-95

Code: 28262 **1995 RVUs:** 12.19 **Recommended RVUs:** 16.20 **Ratio:**

Long Descriptor: Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 55 **Impact:** 221

Source: 1 **Year:** 92 **Public Comment Letter:** 347

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP, APMA

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28262	73	40	-26

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28262	42.5	60	8.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28262	orthopedic surgery	70
	podiatry	30

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28262							
	AAOS	090	090	11.11	12.19	1.10	12.19

Public Comments

30-Jun-95

AAP	090	090	11.11	12.19	1.10	12.19
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28262								
AAOS	12.19	12.19	1.10	1.00	1.00	1.00	.	
AAP	12.19	12.19	1.10	1.00	1.00	1.00	16.20	347

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
28262								
AAOS	090	11.11		28	*	104		40
AAP	090	11.11		28	*	104		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
28262									
AAOS	*	1.0	*	10	3.5	*	10	0.0	4.0
AAP	*	1.0	*	10	3.5	*	10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
28262									
AAOS	*	10		.	12.19	or	3		0.065
AAP	*	10		16.20	12.19	or	3		0.065

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 28261 Global Period: 090 1995 RVW: 8.92 Recommended RVW: 12.00
Workgroup Recommended New Value: 10.95

CPT Descriptor: Capsulotomy, midfoot; with tendon lengthening

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 9-month-old girl has residual equinus and forefoot adduction following conservative treatment for a clubfoot. She undergoes midfoot capsulotomies and lengthening of the foot and ankle tendons.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of x-rays, preoperative plan, lab work; review patient history, especially allergies, medical problems, and family history; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; arranging for intraoperative x-ray, leg tourniquet, advise as to intraoperative drugs, antibiotics; positioning the patient on OR table, apply Webril and tourniquet to leg and steridrape protector; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: The initial incision is a posterior medial ankle incision halfway between the Achilles tendon and the medial malleolus in a longitudinal fashion, starting at the os calcis and going proximally about 2-3 inches. The dissection is conducted down through the subcutaneous fat and then directed posteriorly toward the Achilles tendon. This must be dissected free from the tendon sheath attachments from the os calcis proximally to the musculotendinous junction. The plantaris tendon is identified and cast, or tenotomized. A moist tongue blade is then passed behind the Achilles tendon with the foot in equinus and a step cut incision is performed with a number I surgical blade. The incision is begun in the middle of the tendon distally on the medial side, cutting half of the tendon from the middle to the medial side. The incision is then carried longitudinally through the center of the tendon proximally to the musculotendinous junction where a second transverse incision is performed, this time going laterally. This normally allows the foot to come into a neutral, or dorsiflexion, position.

A second incision is now made for the medial release as a curvilinear incision from the base of the first metatarsal back to the tip of the medial malleolus. The curve is directed toward the dorsum of the foot. Again, dissection is carried through the soft tissues, cauterizing any bleeders seen. Once a dissection is down onto the medial capsules, we then identify the metatarsal/medial cuneiform joint. A transverse incision is made to open up this joint. That involves dissecting the tibialis anterior tendon free but not releasing it. The capsule of this joint is released dorsally, medially and on the plantar surface. Secondly, the medial cuneiform/ navicular joint is identified and a similar transverse release is accomplished sharply by scalpel, releasing the dorsal, medial and plantar portions of the capsule. Finally, the talo-navicular joint is identified and this joint is also released in a similar fashion.

Intraoperative work (continued):

A manipulation of the foot is then conducted by holding the heel of the hand against the lateral border of the hindfoot and pushing the forefoot over by pressure against the first metatarsal head. This should allow the foot to become straight or with some metatarsal abducted position. In that position, an .062 smooth K-wire is then drilled between the first and second metatarsals and headed proximally across the various joints into the talus to hold the reduction achieved by the manipulation. All the wounds are irrigated, If the forefoot continues to roll into inversion, then the posterior incision is reinspected and dissection is carried down to identify the tibialis posterior tendon which is released from its tendon sheath. This is usually found to be excessively tight and needs to be lengthened by a step cut release as described for the Achilles tendon. The lengthened tendons are then repaired with a non absorbable 0 or I suture. Both incisions are irrigated and the subcutaneous tissues are approximated with 3.0 interrupted suture. A running 4.0 subcuticular suture is used to close both skin incisions.

Postoperative work begins after skin closure in the operating room and includes application of dressing, Webril and mold cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring lab studies; x-rays as needed; vital signs, etc.; care and removal of cast and pin; supervision of home health nursing if necessary; ordering and reviewing postoperative X-rays; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, internal fixation pins and cast changes; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America; American Orthopaedic Foot and Ankle Society

Survey n:	244	PRE	INTRA	POST							
Response:	62			RVW	total min	total min	Day 1 total min	ICU		Hosp. - Other		Office
Rate %:	25%	total min	# visits					total min	# visits	total min	# visits
low	9.00		45								
25th%	10.00		90								
med	12.00	60	103	30	0	0	30	2	75	4	
75th%	13.98		131								
high	20.00		240								

HARVARD DATA for surveyed service and key reference service(s):

Harvard 28261:	40	74	20	0	0	15	1.5	40	4
Harvard 28262:	48	104	30	0	0	35	3.5	40	4
Harvard 27165:	55	147	28	0	0	99	9	60	5
Harvard 63017: Phase 4	66	168	10	0	0	70	7	45	3

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
16.20	090	27165 Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
9.80	090	28264 Capsulotomy, midtarsal (Heyman type procedure)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
(12.19/15.00)*	090	28262	Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity
16.20	090	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
16.03	090	63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; lumbar

*Note: this procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 12.19 to 15.00, is being presented.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The exposure and overall work of CPT 28261 (Capsulotomy, midfoot; with tendon lengthening) is less extensive, but similar to the each of the reference services: CPT 28262, CPT 27165, and CPT 63017.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the Harvard study did not correctly estimate the intraoperative time for patients requiring CPT 28261 and CPT 28262. A discussion that compares CPT 28262 to CPT codes 27165 and 63017 is presented on a summary of recommendation form for that code. Because pre- and postoperative care for CPT 28262 is similar to 28261, it is reasonable to calculate an RVW for 28261 based on the difference in intraoperative times.

To calculate an RVW for CPT 28261, that is "relative" to the recommended* RVW for CPT 28262, but is adjusted for intraoperative differences, one would subtract the portion of the intra-RVW** for CPT 28262 that represents the additional intraoperative time for this procedure over CPT 28261, as follows:
 $[9.00 \times (37/140) = 2.38]$; $[15.00 - 2.38 = 12.62]$.

The survey median RVW of 12.00, which is less than the calculated RVW, takes into account the difference in intraoperative intensity for the more extensive intraoperative work of CPT 28262 over CPT 28261.

*Note: this procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 12.19 to 15.00, is being presented.

The **intraoperative RVW for the recommended total RVW for CPT 28262 is 9.00. [This is equal to 60% of the total RVW, per Harvard's estimation of intra- vs. pre-/postoperative "work" (not time), as reported in Harvard Phase 3 - Final Report.]

Public Comments

05-Jul-95

Code: 28261

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Capsulotomy, midfoot; with tendon lengthening

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP, APMA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
28261	80	40	20	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28261	332	346	2.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28261	11.7	7.5	-2.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28261	orthopedic surgery	13.3
	podiatry	86.1

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28261							
AAOS		090	090	8.11	8.92	1.10	8.92

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28261								
AAOS	8.92	8.92	1.10	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
28261								
AAOS	090	8.11		25	*	74		30

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
28261									
AAOS	*	0.5	*	10	1.5	*	10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
28261									
AAOS	*	10		.	8.92	or	3		0.063

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 28309 Global Period: 090 1995 RVW: 8.83 Recommended RVW: 12.00
Accepted by Workgroup

CPT Descriptor: Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure)

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 15-year-old with cavus foot deformity due to neuromuscular disease undergoes multiple metatarsal osteotomies to correct the deformity.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to x-ray review, alignment of lower extremity ipsi and contralateral; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: To perform multiple metatarsal osteotomies for a cavus foot, one must first release the tightened plantar fascia and plantar structures from the prolonged cavus deformity. A medial incision is made at the junction of the medial and planter skin over the heel. Careful blunt and sharp dissection is carried out, care being taken to avoid branches of the calcaneal nerve. The plantar fascia is exposed and cut from its origin at the calcaneal tuberosity. Further dissection is then carried out to release the intrinsic musculature from its origin on the calcaneus right up to the calcaneocuboid joint. A second medial incision is made at the junction of the medial and plantar skin in the midportion of the arch. Small crossing veins are cauterized. Blunt and sharp dissection reveals this portion of the plantar fascia. It is carefully identified and cut across the bottom of the foot.

With the planter fascia and intrinsic musculature adequately released, tension is directed dorsally to the metatarsals. Metatarsal 1 is approached through a dorsomedial incision, metatarsals 2 and 3 through an intermetatarsal incision between 2 and 3, and metatarsals 4 and 5 through intermetatarsal incision between 4 and 5, these being longitudinal incisions approximately 3 inches in length. The respective metatarsal is approached with blunt and sharp dissection, subperiosteally dissected over the area of the osteotomy site, and a dorsal lateral wedge is created in the respective metatarsal to allow elevation and lateral positioning of the involved metatarsal. When all necessary metatarsals have been osteotomized, they are pinned in place using multiple 0.62 K wires. The position of the metatarsals is assessed through radiographic control, and the position of the metatarsal osteotomies on the position of the foot is assessed so that the foot can be plantigrade with proper distribution of weight bearing in the forepart of the foot. Pins are cut short and bent, left protruding from the skin. All wounds are closed in layers after copious irrigation. Sterile dressing and splint are applied.

Postoperative work begins after skin closure in the operating room and includes application of cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; care and removal of drain; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, removal of internal fixation pins and cast changes; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. The surgeon initiates and orders physical therapy to regain normal ambulatory function and range of motion.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America; American Orthopaedic Foot and Ankle Society

Survey n: 244
 Response: 60
 Rate %: 25%

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1	ICU		Hosp. - Other		Office	
				total min	total min	# visits	total min	# visits	total min	# visits
low	8.80		60							
25th%	10.00		90							
med	12.00	60	110	30	0	0	30	2	75	4
75th%	13.00		124							
high	19.69		180							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 28309:	42	73	22	0	0	15	1.5	40	4
Harvard 27823:	47	117	21	0	0	51	4	50	4
Harvard 28725:	50	89	22	0	0	41	4	50	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
10.90	090 27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip
10.86	090 28725	Subtalar arthrodesis

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
10.90	090	27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip
10.86	090	28725	Subtalar arthrodesis

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 28309 (*Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure)*) requires a more extensive surgical dissection and involves more structures (all metatarsals and soft tissue plantar release), and additional incisions than both CPT 28725 (*Subtalar arthrodesis*) and CPT 28723 (*Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip*).

CPT 28309 requires a more extensive exposure, involves more bones, and additional incisions as compared to CPT 28723

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the Harvard study did not correctly estimate the intraoperative time for CPT 28309. Additionally, the postoperative work which is significantly higher than the reference services CPT 28725 and 28723, was underestimated (through prediction).

Public Comments

05-Jul-95

Code: 28309 **1995 RVUs:** **Recommended RVUs:** **Ratio:**

Long Descriptor: Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure)

Reference Set (y/n): **Global Period:** 090 **Frequency:** **Impact:**

Source: **Year:** **Public Comment Letter:** AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP, APMA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
28309	0	0	0	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28309	121	98	-10

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28309	36.4	20.4	-8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28309	general surgery	6.1
	orthopedic surgery	38.8
	podiatry	55.1

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28309							
	AAOS	090	090	8.07	8.83	1.09	8.83

Harvard Data:

Public Comments05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28309								
AAOS	8.83	8.83	1.09	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
28309								
AAOS	090	8.07		24	*	73		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
28309									
AAOS	*	0.5	*	10	1.5	*	10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
28309									
AAOS	*	10		.	8.83	or	3		0.063

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION ***REVISED 8/14/95***

CPT Code: 27870 Global Period: 090 1995 RVW: 10.42 Recommended RVW: 13.00
Accepted by Workgroup

CPT Descriptor: Arthrodesis, ankle, any method

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

Additionally the Medicare Carrier Medical Directors submitted a comment that this code is undervalued has about two thirds the intraservice work of 27715 *Osteoplasty, tibia and fibula, lengthening* (RVW=12.97) with equal follow-up. CPT 27792 *Open treatment of distal fibular fracture (lateral malleolus) w/wo internal or external fixation* (RVW=7.04) was also cited as a reference service. [CMD recommendation = 12.97]

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male, who sustained a severe intra-articular ankle fracture 20 years ago, undergoes an ankle fusion for traumatic arthritis and mild varus deformity.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging (possible CT scanning of the ankle joint), and laboratory studies; with special attention to X-ray review (AP, lateral and mortise views of the ankle joint), vascular status, alignment of whole lower extremity particularly the hindfoot, ankle and knee (ipsi and contralateral); consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite. Arrangements for the use of portable intra-operative fluoroscopy (C-arm) is made.

Intraoperative work: To perform an ankle arthrodesis, an incision is made over the distal third of the fibula laterally crossing the tip of the fibula until one reaches the anterior process of the calcaneus. Small crossing veins are cauterized, and the distal third of the fibula is subperiosteally dissected. Approximately an inch and a half above the joint line, an oblique osteotomy is made in the fibula with the obliquity being proximal lateral and distal medial. The osteotomy is completed with an osteotome and the distal third of the fibula is dissected free and removed from the field. With careful subperiosteal dissection, the lateral joint line, the anterior joint line and the posterior joint line of the tibiotalar joint are dissected free of any previous scarring from prior trauma or arthritis. The scar tissue is typically adherent to the bone, and sharp dissection must be carefully done to avoid injury to the neurovascular structures.

With the anterior, lateral and posterior portions of the distal tibia and talus visible, osteotomy of the distal tibial articular surface is carried out with a sagittal saw to the level of the medial malleolus and completed with an osteotome. Similarly, a corresponding matching osteotomy of the talar dome is carried out with a sagittal saw and completed with an osteotome. The osteotomy sites are planned and confirmed so that the foot will rest in a neutral plantigrade position with the heel in about 5 to 10 degrees of valgus. Because of impingement of the medial malleolus, the osteotomy sites usually do not come easily together, and a counter-incision is usually made medially over the medial malleolus. The medial malleolus is subperiosteally dissected and approximately one to one-and-a-half centimeters of medial malleolus are removed, allowing the osteotomy sites to coaptate.

Intraoperative work (continued):

Attention is then directed to the sinus tarsi. Subperiosteal dissection of the sinus tarsi and lateral talus expose an area where wires for cannulated screws can be passed from the lateral talar body approaching it from the sinus tarsi through the talus into the distal tibial articular surface and emerging out of the medial tibia above the medial malleolus. Two parallel wires are used emerging from the medial articular surface, sized and then drilled and appropriate lag screws with washers are placed to cause coaptation of the arthrodesis surfaces. These are then checked with x-ray control. The position of the foot is reassessed and it is important to assess the fact that the foot is plantigrade, the forefoot is pronated or supinated, and the heel is in above 5 to 10 degrees of valgus. Copious irrigation is carried out and the wound is closed in layers. The technique may vary somewhat if previous infection was present. In this circumstance, after all infected bone is excised an external fixture is used in the distal tibia and either talus or calcaneus instead of using the screws (as described above) for internal fixation after the joint surface is prepared as described above.

Postoperative work begins after skin closure in the operating room and includes application of cast (or external fixation). Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; care and removal of drain; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging to assess bony fusion and laboratory reports, if needed; and antibiotic and pain medication adjustments. While awaiting fusion, the patients ambulatory status is directed by the surgeon. The amount of weight bearing is dependant on the degree of healing that has occurred. Once complete healing has occurred the surgeon directs the physical therapist in weaning the patient from external support (crutches or cane) to independent weight bearing. Proper footwear prescription is also necessary to achieve an optimal outcome.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association; American Orthopaedic Foot and Ankle Society

Survey n:	289	PRE		INTRA	POST							
Response:	70				Day 1	ICU		Hosp. - Other		Office		
Rate %:	24%	RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits	
		low	10.86	60								
		25th%	12.00	120								
		med	13.00	60	140	30	0	0	40	3	75	4
		75th%	15.00		180							
		high	20.00		240							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27870:	43	120	29	0	0	45	4.5	60	4
Harvard 27170:	65	148	24	0	0	87	7	39	3
Harvard 27715:	52	119	26	0	0	95	9*	57	5*
Harvard 28715:	52	119	23	0	0	45	4*	54	4*
Harvard 28705:	54	137	24	0	0	48	4*	56	5*
Harvard 28725:	50	89	22	0	0	41	4*	50	4*

*Predicted, not surveyed.

Reference services cited most frequently by survey respondents. (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
10.86	090	28725	Subtalar arthrodesis
14.90	090	27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
14.90	090	27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)
12.97	090	27715	Osteoplasty, tibia and fibula, lengthening
10.86	090	28725	Subtalar arthrodesis
14.23	090	28705	Pantalar arthrodesis
12.18	090	28715	Triple arthrodesis

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27170 (Repair/graft femur head/neck) involves the same work as CPT 27870 in terms of time. Additionally, similar postoperative imaging is necessary in both until bone healing (of fusion) has been achieved.

CPT 27715 (Revision of lower leg) requires less intraoperative work when compared to CPT 27870 in terms of time. Additionally, similar postoperative imaging is necessary in both until bone healing (of fusion) has been achieved.

CPT 28725 (Subtalar fusion) is a tarsal arthrodesis procedure in which the talus is fused to the calcaneus in order to provide a stable "platform" upon which to stand and walk in conditions of pain (eg, rheumatoid arthritis and post traumatic arthritis) and instability (eg, posterior tibial tendon rupture and neuromuscular imbalance). The subtalar joint is exposed through a lateral hind foot incision. The articular surface is denuded down to bleeding subchondral bone. A local bone graft is used, followed by internal fixation with staples or a screw inserted from the plantar aspect of the calcaneus and extending across the subtalar joint into the talus. A cast is always used until bony fusion is achieved. Pre-service work of 28725 is similar to 27870. Intra-service work and time is greater for 27870 than 28725. Post-service work is somewhat higher for 27870 as compared with 28725 because the time to achieve fusion is greater and the likelihood of any fusion at all is less certain with 27870 as compared with 28725 (higher non-union rate with 27870 than 28725).

CPT 28715 (Triple arthrodesis) requires two incisions and precision in the amount of bone resected from all three joints in order to properly balance the hind foot with the mid- and fore-foot. An oblique skin incision is made directly over the sinus tarsi. The extensor tendons are mobilized and retracted medially. The peroneal tendons and the sural nerve are identified and protected. The origin of the extensor digitorum brevis muscle is mobilized to expose the sinus tarsi. The fatty tissue within the sinus tarsi is excised with a rongeur. With sharp dissection this muscle is further dissected distally thereby exposing the calcaneocuboid joint. The talonavicular joint can typically be visualized within the sinus tarsi. Osteotomes are used to remove the articular cartilage of the calcaneocuboid joint and the underlying subchondral bone. This will further allow visualization of the talonavicular joint. The cartilage and subchondral bone is removed in a similar manner.

CPT 28715 (Triple arthrodesis) continued:

This joint is more convex and several cuts are frequently necessary in order to adequately excise the joint. A small medial incision is sometimes necessary in order to visualize the navicular tuberosity and more completely excise the talonavicular cartilage and subchondral bone. Using an osteotome the posterior facet of the subtalar joint is excised next. This is followed by the medial facet. Care must be taken when excising the medial facet to avoid transacting the flexor hallucis longus tendon. When all three joints have been excised the foot is positioned in the reduced or corrected position. This is typically accomplished by abducting the midfoot which then pushes the calcaneus posteriorly. Final alignment is achieved by excising wedges of bone to achieve the desired position of each joint. Typically, the wedges are removed from the lateral aspect of the calcaneocuboid and subtalar joints. This will allow correction of hindfoot varus and forefoot adduction. Once the final alignment is achieved the two or three joints are stabilized with Blount staples. Intraoperative radiographs are obtained to assess position. Any remaining fragments of cancellous bone from the excised bone fragments is packed into the sinus tarsi and any other spaces of the three joints. The extensor digitorum brevis muscle is repaired over the area of the sinus tarsi. Comparisons between reference service 28715 and surveyed service 27870 demonstrate similarities in terms of pre- and intra- service work and times. Post-service work is more variable and problematic since the non-union rate of CPT 27870 is higher than CPT 28715 with, therefore, a greater amount of post-service time and work. Overall, CPT 27870 represents a somewhat greater degree of work than 28715.

CPT 28705 (Pantalar arthrodesis) is a tarsal arthrodesing operation in which all bones articulating with the talus are fused (tibia, calcaneus, navicular and well as calcaneocuboid). As such, CPT 28705 involves the work of both CPT 28715 (Triple arthrodesis) and CPT 27870 (ankle arthrodesis). To perform a pantalar arthrodesis, an incision is made on the lateral side of the ankle along the lateral border of the fibula covering its distal third, extending to the base of the 4th metatarsal, establishing the neural interval between the superficial peroneal nerve and the sural nerve. The distal third of the fibula is subperiosteally dissected. An oblique osteotomy is made 1 inch to 2 inches above the lateral joint line with an obliquity proximal, lateral, distal medial. The osteotomy is made with a sagittal saw. The distal portion of the fibula is dissected away and removed from the operative field. The soft tissue and scar tissue covering the lateral tibiotalar joint are removed and careful sharp dissection reveals the anterior, posterior and lateral surfaces of the distal tibia and the talus. The sinus tarsi is exposed by mobilizing the sinus tarsi fatpad along with the adjacent origin of the extensor brevis musculature which is brought up as a flap after subperiosteally dissecting the contents of the sinus tarsi out, and sharp and blunt dissection is carried out to a point to where the subtalar posterior facet, middle facet, and anterior facets are carefully visualized. Also the calcaneal cuboid joint is visualized and the lateral portion of the talonavicular joint is visualized. Lamina spreaders are placed within the sinus tarsi and within the involved joints, and careful decortication of the articular surface of the subtalar joints, calcaneocuboid joint, and the lateral portion of the talonavicular joint are carried out. Using an oscillating saw, distal articular surface of the tibia is removed up to the level of the medial malleolus, and a coapting surface of the talus is removed corresponding to the tibial articular surface. To allow the surfaces to coapt, a counter incision is made over the medial malleolus, and one to one-and-a-half centimeters of medial malleolus is removed so the tibiotalar surface coapts nicely. Another incision is made medially over the talonavicular joint. The posterior tibial tendon is mobilized and the medial portion of the talonavicular joint is decorticated. Assessment of the foot is then carried out and wedges are taken in the subtalar or calcaneocuboid joint to create a foot that has a hindfoot in 5 to 10 degrees of valgus, a forefoot in neutral varus or valgus, and a foot that is plantigrade. Temporary fixation is carried out with guide wires and x-rays confirm position. At this time the tightness of the Achilles tendon is assessed, and if necessary, it is percutaneously lengthened. With proper position, the calcaneocuboid joint is fixed with a staple and/or a screw. The subtalar joint is fixed with large lag screws from the calcaneus into the talus, and the tibiotalar joint is fixed with large oblique lag screws from the lateral talus at the level of the sinus tarsi up through the tibia emerging out above the medial metaphyseal surface. If correction is needed for lengthening of the lateral column or to correct excess valgus of the heel, tricortical iliac crest grafts are taken to be inserted at the appropriate spot. After good fixation and reassessment of the position, copious irrigation is carried out. The wound is closed in layers after drains have been inserted.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work; time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The current AMA/RUC survey and comparison to key reference services, the judgment of the AAOS RVS Advisory Panel, and the Medicare CMDs equate this service to more work than CPT 28725, 28715 and 27715, less work than CPT 28705, and similar to CPT 27170.

In 1992, the "foot bone fusion" family of codes was reviewed as part of the HCFA refinement process. Table 1 presents the results of HCFA's review.

CPT	Description	1992 RVW	Requested RVW	1993 RVW*	Basis for Decision**	1995 RVW
27870	Arthrodesis, ankle, any method	10.99	13.50	X	1	10.42
28705	Pantalar arthrodesis	11.27	15.25	14.58	2	14.23
28715	Triple arthrodesis	10.36	13.75	12.48	2	12.18
28725	Subtalar arthrodesis	9.14	12.00	11.12	2	10.86
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	8.22	12.00	10.15	2	9.91
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy as for flatfoot correction	10.60	11.70	X	1	10.07
28737	Arthrodesis, midtarsal navicular-cuneiform, with tendon lengthening and advancement (Miller type procedure)	7.46	10.25	9.11	2	8.89

Source: Federal Register, Vol. 57, No. 228, November 25, 1992, pp. 55921-2.

*X indicates no change.

**A "1" indicates the refinement panel recommended no change. A "2" indicates a new value emerged from the analysis of the refinement panel ratings.

As a result of the 1992 refinement process, a family anomaly was created, where CPT 27870 was not revalued along with other family ankle and hind foot arthrodesis codes. The original RVW established for CPT 27870 was set appropriately greater than 28715 and less than 28705. The current AMA/RUC survey median of 13.00 and the CMD recommended value of 12.97 emphasize that the RVW for CPT 27870 should be between the current RVW for CPT 28715 (RVW=12.18) and CPT 28705 (RVW=14.23). **Therefore, the survey median RVW of 13.00 is recommended for CPT 27870.**

In addition, Table 2 on the next page shows that the calculated IWPUT for the recommended RVW of 13.00 is more in-line with the other services in the family for foot bone fusion codes.

CMD Comments

30-Jun-95

Code: 27870

1995 RVUs: 10.42

Recommended RVUs: 12.97

Ratio: 0.24

Long Descriptor: Arthrodesis, ankle, any method

Reference Set (y/n): N

Global Period: 090

Frequency: 1,884

Impact: 4804.2

Source: 4

Year: 93

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
27870			
	27715 REVISION OF LOWER LEG	12.97	090
	27792 REPAIR OF ANKLE FRACTURE	7.04	090

CMD Comment:

27870 has about two thirds the intraservice work of 27715 with equal follow-up

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP, APMA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27870	20.8	2.1	10.4	58.3	29.2	0	0	14.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27870	1781	2144	9.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27870	89.1	83.8	-2.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27870		
	orthopedic surgery	95.1
	podiatry	2.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
27870			
	714	1.6	RHEUMATOID ARTHRITIS AND OTHER I
	715	13.5	OSTEOARTHRITIS AND ALLIED DISORD

CMD Comments

30-Jun-95

716	3.1	OTHER AND UNSPECIFIED ARTHROPAT
718	1	OTHER DERANGEMENT OF JOINT
719	1.6	OTHER AND UNSPECIFIED DISORDERS O
733	3.1	OTHER DISORDERS OF BONE AND CART
824	2.1	FRACTURE OF ANKLE
V54	1.6	OTHER ORTHOPEDIC AFTERCARE

Harvard Data:

Comm	Modif	Packhvr	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27870							
AAOS		090	090	10.50	10.42	0.99	10.42
CMD		090	090	10.50	10.42	0.99	10.42

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27870								
AAOS	10.42	10.42	0.99	1.00	1.00	1.00	15.39	25
CMD	10.42	10.42	0.99	1.00	1.00	1.00	12.97	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27870								
AAOS	090	10.50		24		120		38
CMD	090	10.50		24		120		38

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27870									
AAOS		1.0		10	4.5		10	0.0	4.0
CMD		1.0		10	4.5		10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
27870									
AAOS		15		15.39	10.42	or	3		0.049
CMD		15		12.97	10.42	or	3		0.049

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 28750 Global Period: 090 1995 RVW: 4.77 Recommended RVW: 8.00
Workgroup Recommended New Value: 6.90

CPT Descriptor: Arthrodesis, great toe; metatarsophalangeal joint

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

Additionally, the American Podiatric Medical Association submitted a request for review of 28750 (public comment HCFA control number 216) as an undervalued procedure. CPT codes 28296 (work is similar) and 26841 (work is less) were cited as key references. [APMA recommendation = 7.77]

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38-year-old truck driver with severe degenerative arthritis of the big toe metatarsophalangeal joint undergoes an arthrodesis of this joint.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to x-rays, examination of ipsi and contralateral lower extremity; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: To perform an arthrodesis of the great toe, metatarsophalangeal joint: with the patient in the supine position, a medial incision is made to the metatarsal phalangeal joint. Blunt dissection protects the associated neural structures. Small crossing veins are cauterized. The capsule is opened along the course of the incision and subperiosteally reflected dorsally and proximally. The joint is visualized, and Homan retractors are inserted to expose the ends of the 1st metatarsal and base of the proximal phalanx. Matching cuts are made in the distal metatarsal and the proximal phalanx so as to effect a union of the two bones that will result in 20 degrees of dorsiflexion to 10 degrees of medial deviation of the great toe without any axial rotation. The angles may vary as to the individual needs of the patient. With the two surfaces firmly coapted, the osteotomy is held together with two lag screws and/or a small fragment plate. In bone which is severely osteoporotic large threaded Stinman pins are drilled across the osteotomy site as internal fixation. Copious irrigation is carried out and the wound is closed in layers.

Postoperative work begins after skin closure in the operating room and includes application of cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; and antibiotic and pain medication management; Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, cast changes and pin removal (if used); evaluation of periodic imaging until bone fusion occurs and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; American Orthopaedic Foot and Ankle Society

	Survey n: Response: Rate %:	176 49 28%	RVW	PRE	INTRA	POST						
				total min	total min	Day 1	ICU		Hosp. - Other		Office	
						total min	total min	# visits	total min	# visits	total min	# visits
low			5.30		45							
25th%			6.25		63							
med			8.00	40	75	30	0	0	0	0	60 4	
75th%			8.90		90							
high			11.25		120							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 28750:	40	51	23	0	0	0	0	35	3.5
Harvard 28293:	40	72	23	0	0	12	1	47	4
Harvard 28296:	51	90	23	0	0	15	1	49	4
Harvard 26841:	37	74	21	0	0	6	0	47	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
10.86	28725	Subtalar arthrodesis
7.04	27792	Open treatment of distal fibular fracture (lateral malleolus), with or without internal or external fixation

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
6.79	090	26841	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;
8.25	090	28293	Hallux valgus (bunion) correction, with or without sesamoidectomy; resection of joint with implant
8.69	090	28296	Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 28293 (*Hallux valgus (bunion) correction, with or without sesamoidectomy; resection of joint with implant*) is identical to CPT 28750 (*Arthrodesis, great toe; metatarsophalangeal joint*) as far as exposure and prep, but instead of reconstruction with an implant, the procedure involves performing an exacting alignment and fixation.

The intraoperative work of CPT 28750 is greater than CPT 26841 (*Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;*) because arthrodesis of the great toe generally requires skeletal fixation. Also, postoperative complications associated with the fusion of a weightbearing joint are greater than the carpometacarpal joint of the thumb.

The total work of CPT 28750 closely approximates the work of CPT 28296 (*Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)*).

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The current AMA/RUC survey and the judgment of the Advisory Panel equate this service to more work than 26841 and similar to 28293 and 28296. as discussed in the comparison to key reference services section. As such, the survey median RVW, is recommended to set an appropriate value for CPT 28750 "relative" to these codes.

Public Comments

30-Jun-95

Code: 28750

1995 RVUs: 4.77

Recommended RVUs: 7.77

Ratio:

Long Descriptor: Arthrodesis, great toe; metatarsophalangeal joint

Reference Set (y/n): N Global Period: 090 Frequency: 2,164 Impact: 6492

Source: 1 Year: 92 Public Comment Letter: 216

Reference Services:

CMD Comment:

--

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP, APMA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
28750	40	1.8	3.7	72.7	5.5	0	0	5.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28750	2111	2521	9.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28750	52.3	40.8	-5.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28750	orthopedic surgery	79.2
	podiatry	17.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
28750	714	5	RHEUMATOID ARTHRITIS AND OTHER I
	715	4.5	OSTEOARTHRITIS AND ALLIED DISORD
	719	1.4	OTHER AND UNSPECIFIED DISORDERS O
	726	2.3	PERIPHERAL ENTHESOPATHIES AND AL
	727	3.2	OTHER DISORDERS OF SYNOVIUM, TEN

Public Comments

30-Jun-95

735	15.5	ACQUIRED DEFORMITIES OF TOE
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28750							
AAOS		090	090	4.63	4.77	1.03	4.77
APMA		090	090	4.63	4.77	1.03	4.77

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28750								
AAOS	4.77	4.77	1.03	1.00	1.00	1.00	.	
APMA	4.77	4.77	1.03	1.00	1.00	1.00	7.77	216

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
28750								
AAOS	090	4.63		18		51		35
APMA	090	4.63		18		51		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	lcuvis	Offvis
28750									
AAOS		0.0		0	0.0		0	0.0	3.5
APMA		0.0		0	0.0		0	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
28750									
AAOS		10		6.46	4.77	or	3		0.042
APMA		10		7.77	4.77	or	3		0.042

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 28740 Global Period: 090 1995 RVW: 6.20 Recommended RVW: 9.95
Workgroup Recommended New Value: 7.40

CPT Descriptor: Arthrodesis, midtarsal or tarsometatarsal, single joint

Source and Summary of Comment to HCFA on this service: The American Orthopaedic Foot and Ankle Society (AOFAS), a group of orthopaedists specializing in ankle and foot conditions, identified four interrelated midfoot arthrodeses procedures as currently undervalued within a larger group of undervalued Foot Reconstructive Procedures. On behalf of AOFAS, the American Academy of Orthopaedic Surgeons included those four orthopaedic codes on its list of codes to survey during the five-year review process. CPT 28730 is one of the codes AOFAS considers undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female with rheumatoid arthritis and advanced arthritic changes at the talonavicular joint and sparing of the associated joints undergoes an arthrodesis of only the talonavicular joint.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to X-rays, evaluation of ipsi and contralateral lower extremity; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: To perform an arthrodesis of a single midtarsal joint, with the patient in a supine position, a medial longitudinal incision is made over the talonavicular joint. Small crossing veins are cauterized. Blunt and sharp dissection reveals the joint after opening the capsule. The posterior tibial tendon is mobilized and reflected plantarward, and the entire talonavicular joint is visualized both dorsally, plantarward, and medially. With dissection and use of small curettes and small rongeurs, the articular surface is completely removed from the talonavicular joint surfaces. With the foot in proper orientation, the talonavicular joint is positioned, a guide wire is placed across and x-rays confirm the position. One or two screws are then passed from the distal surface of the navicular across the talonavicular joint into the talus under x-ray control. Following good fixation and copious irrigation, the mobilized posterior tibial tendon is resutured, the capsule is closed. The wound is further closed in layers after copious irrigation

Postoperative work begins after skin closure in the operating room and includes application of splint/cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; care and removal of drain; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures and cast changes; evaluation of periodic imaging until bone fusion has occurred and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; American Orthopaedic Foot and Ankle Society

Survey n:	176	PRE	INTRA	POST						
Response:	45			Day 1	ICU		Hosp. - Other		Office	
Rate %:	26%	total min	total min		total min	# visits	total min	# visits	total min	# visits
	RVW									
	low	6.80	60							
	25th%	8.35	60							
	med	9.95	80	30	0	0	20	1	60	4
	75th%	14.45	90							
	high	14.50	135							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 28740:	44	58	28	0	0	10	1	35	3.5
Harvard 28725:	50	89	22	0	0	41	4	50	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
10.86	28725	Subtalar arthrodesis
9.80	28264	Capsulotomy, midtarsal (Heyman type procedure)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
10.86	090	28725	Subtalar arthrodesis

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 28725 (*Subtalar arthrodesis*) involves more work and time than CPT 28740 (*Arthrodesis, midtarsal or tarsometatarsal, single joint*) due to a greater exposure and more fusion.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the judgment of the Orthopaedic RVS Advisory Panel that is making this recommendation that CPT 28740 is slightly less work than CPT 28725 because it involves less exposure and less fusion. As such, the survey median RVW is recommended to set an appropriate value for CPT 28740 "relative" to CPT 28725.

Public Comments

05-Jul-95

Code: 28740 1995 RVUs: 6.20 Recommended RVUs: Ratio:

Long Descriptor: Arthrodesis, midtarsal or tarsometatarsal, single joint

Reference Set (y/n): Global Period: 090 Frequency: Impact:

Source: Year: Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP, APMA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
28740	20	0	5	85	15	0	0	5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28740	570	656	7.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28740	47.4	43.6	-1.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28740	orthopedic surgery	61.3
	podiatry	33.5

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28740							
	AAOS	090	090	6.11	6.20	1.01	6.20

Harvard Data:

Public Comments05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28740								
AAOS	6.20	6.20	1.01	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
28740								
AAOS	090	6.11		22	*	58		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
28740									
AAOS	*	0.5	*	10	1.0	*	10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
28740									
AAOS	*	10		.	6.20	or	3		0.054

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27580 Global Period: 090 1995 RVW: 12.26 Recommended RVW: 19.69
Workgroup Recommended New Value: 18.20

CPT Descriptor: Fusion of knee, any technique

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 76-year-old female presents with failure and persisting sepsis of a secondary total knee implantation after a treated infected primary total knee arthroplasty. The implants are removed and the infection treated. A knee arthrodesis (fusion) is subsequently performed.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of radiographs and scaled radiographs if necessary for sizing, ordering and review of knee aspiration/arthrogram if necessary, and review of preoperative laboratory tests; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; arranging for intraoperative cell saver; positioning the patient; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: The knee is frequently totally unstable, hyperextending 30 degrees, going mediolateral 30 degrees, flexing to 90. The old anterior skin incision is used, carried down to the fascia along the surface which has generally dense scar tissue. This is incised where a normal median parapatellar incision would be performed. If a patella is still present it may be used for local bone graft. Any fluid is cultured. Removal of all scar tissue between the ends of femur and tibia must be done. We then dissect and debride all the soft tissues off the femoral condyle exposing the end of the bone. We then isolate the proximal tibia where significant bone loss is frequently found to have occurred. Having cleaned up all of the soft tissues in the area, we then open up the femoral intramedullary canal, pass progressive reamers to 17 mm. and then impact the preoperatively planned 17 mm. diameter femoral rod. This is then driven to a level where a saw cut could be made taking off only a few millimeters of bone but creating flat cancellous bone surfaces. Using a femoral saw guide with a complete exposure, we then attach the femoral locking screw guide and place drill holes through the femur and over the first hole there is overdrilling of the bone on the medial cortex. A screw is inserted. We then turn our attention to the tibia. This is reamed, followed by driving in the tibial rod with attached collar. Having driven it into the appropriate level, the saw guide is then attached to this and the proximal tibia cut revealing a 1-2 mm. bone loss but a flat area of contact with minimal intact bone medially. We then take off the cutting guide and attach the drill guide and place two more 5 mm. screws through the tibia in locking holes of the intramedullary rod. These are done through stab wounds in the skin. Having placed these and confirmed their position fluoroscopically, we then attempt to reduce the joint. The fibula remains quite proud here in its locked, closing the gap between the bone.

Intraoperative work (continued):

We then shell out the proximal tibia, taking great care to not go around the sides of it and avoid injury to the peroneal nerve, having shelled it out, saving this bone, we can then reduce the device to bring the bone in together. Having brought everything into alignment, we then tighten the collar on the tibial rod over the thread to the ends of the femoral rod. Using a wrench to stabilize the femoral rod, tighten the collar until bone compression and firm locking of the two devices have been obtained. To achieve this we cut a small window, the anteromedial tibia, to insert the pins for spinning the collar and a small window to apply the wrench and stabilize the femoral component. Having completed all of this, the two bone ends are securely opposed and pressed together in absolutely rigid straight leg with foot pointing straight up. We then carefully expose all of the adjoining and opposing bony surfaces and then pack all of the bone that had been removed in the resection. Earlier we had irrigated thoroughly with antibiotic solution. We then close over ConstaVac drain after checking everything with fluoroscope, repairing the fascia and subq with Vicryl and the skin with stainless steel staples. We also close the stab wounds.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressing and extension splint. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring lab reports; care and removal of drains and dressings; supervision of physical or occupational therapy; ordering and reviewing postoperative X-rays; and antibiotic and pain medication management. Critical wound care and inspection is required when such a procedure is done following a septic total joint as described in the vignette. Recurrent purulent drainage must be evaluated and treated promptly. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care including home health care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. Supervision and the prescription of physical therapy to regain ambulatory status with either crutches or a walker is critical to the success of the operation. Weight bearing must be appropriately ordered depending on the stability of the fusion site as determined at surgery and the progression of fusion as identified by periodic X-rays.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; American Association of Hip and Knee Surgeons; Orthopaedic Trauma Association

Survey n: 225
 Response: 40
 Rate %: 18%

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1	ICU		Hosp. - Other		Office	
				total min	total min	# visits	total min	# visits	total min	# visits
low	14.00		90							
25th%	16.25		120							
med	19.85	60	150	30	0	0	75	5	75	4
75th%	22.00		180							
high	35.00		240							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27580:	58	130	30	0	0	65	6.5	45	4.5
Harvard 27447: Phase 4	58	139	37	0	0	100	10	60	4

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
19.69	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)
15.98	27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
19.69	090	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27580 (*Fusion of knee, any technique*) is the same intraoperative procedure in terms of depth (e.g., exposure, bone cuts, intraoperative radiographs to assess alignment, graft/prosthetic implant) and degree (intensity) as compared to CPT 27447 (*Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)*) until the point of closure, when fixation is performed for CPT 27580 and arthroplasty is performed for CPT 27447. Postoperative care (e.g., review of radiographs, monitoring neurovascular recovery) is also similar for both procedures. With CPT 27580 the physician must assess the progress of bone healing on X-ray while with CPT 27447 one assesses range of motion progress.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Because CPT 27580 compares well with the RVW for the key reference service (CPT 27447), as discussed in the comparison to key references section, the current value for 27447 is recommended instead of the higher survey median..

Public Comments

05-Jul-95

Code: 27580

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Fusion of knee, any technique

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27580	40	10	40	30	30	0	10	11.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27580	667	499	-13.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27580	89.5	92.8	1.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27580	group practices	3.2
	orthopedic surgery	94.4

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27580							
AAOS		090	090	12.17	12.26	1.01	12.26

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27580								
AAOS	12.26	12.26	1.01	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27580								
AAOS	090	12.17		36		130		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27580									
AAOS		0.5	*	10	6.5		10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27580									
AAOS		10			12.26	or	3		0.047

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 23802 Global Period: 090 1995 RVW: 14.67 Recommended RVW: 19.00
Workgroup Recommended New Value: 15.62

CPT Descriptor: Arthrodesis, shoulder joint; with primary autogenous graft (includes obtaining graft)

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old female with a history of a septic shoulder joint treated at age 20, presents with a painful limited motion shoulder joint that is markedly degenerated on X-ray. A shoulder arthrodesis (fusion) with an iliac bone graft is performed.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; ordering preoperative antibiotics; arranging for intraoperative radiographic/fluoroscopic exposure; prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite. The surgeon carefully positions the patient in a "beach chair" or semi-sitting position on the operating table. This may involve using a Mayfield head support at the top of the table to ensure free access to the anterior, lateral and posterior aspects of the shoulder.

Intraoperative work: Under general anesthesia, and with the patient in a lateral decubitus position, an incision is made parallel to the posterior iliac crest, dissection is carried down through subcutaneous fat to the bone. We elevate subperiosteally and the muscle is reflected off the outer cortex. We then split the iliac crest with osteotome and remove the outer cortex and then use the gouge to remove cancellous bone in the posterior superior iliac spine. After completely removing all of this cancellous bone, we thoroughly irrigate the wound with antibiotic containing solution. The bone is set aside, protected in a sterile fashion for later on in the procedure. We then close the posterior iliac crest with Vicryl over a drain and use stainless steel staples on the skin. Sterile dressing is applied. An anterior lateral incision is made in the shoulder joint and a capsulectomy performed. The spinus scapulum acromion is identified. The undersurface of the acromion is denuded of its soft tissue and cancellous bone as is the glenoid and the head of the humerus denuded of its cartilage. After preparing the glenohumeral joint for an arthrodesis by denuding all articular cartilage from the humeral head and glenoid. Next, the shoulder joint is reduced and held in the desired position of fusion by using an 8 hole compression plate that had been bent, securing compression plate both to the spine of the scapula, to the acromion, and to the proximal humerus. Screws are also placed across the glenohumeral joint in order to provide for good fixation of the shoulder joint. The wound is irrigated with a saline and antibiotic solution. An X-ray is taken to assess fixation of the shoulder joint. Subcutaneous and fascial sutures are placed in an interrupted manner.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and a spica cast or brace. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring upper extremity neurologic and vascular status; wound evaluation daily; care and removal of the drain; adjustments of the cast/brace; supervision of ambulation and instruction in self-care activities and restrictions; ordering and reviewing radiographs; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and planned physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; assessment of physiotherapy progress; evaluation of periodic imaging to assess bony fusion and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; American Shoulder and Elbow Surgeons

Survey n:	106	PRE	INTRA	POST							
Response:	22			RVW	total min	total min	Day 1 total min	ICU		Hosp. - Other		Office
Rate %:	21%	total min	total min					total min	total min	# visits	total min	# visits	total min	# visits
	low	15.00		120							
	25th%	16.00		120							
	med	19.00	45	180	30	0	0	45	3	75	5
	75th%	20.30		210							
	high	25.00		300							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 23802:	53	165	30	0	0	50	5	50	5
Harvard 23472:	60	142	38	0	0	50	5	40	4
Harvard 27284:	59	195	35	0	0	75	7.5	55	5.5

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
18.68	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft
18.10	27158	Osteotomy, pelvis, bilateral (eg, for congenital malformation)
19.69	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
(16.09/19.18)*	090	23472	Arthroplasty with glenoid and proximal humeral replacement (eg, total shoulder)
(15.62/19.75)**	090	27284	Arthrodesis, hip joint (includes obtaining graft);

*Note: this procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 16.09 to 19.18, is being presented.

**Note: this procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 15.62 to 19.75, is being presented.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 23802 (*A rthrodesis, shoulder joint; with primary autogenous graft (includes obtaining graft)*) is similar to CPT 27284 (*A rthrodesis, hip joint (includes obtaining graft);*) in terms of degree and depth of intraoperative work.

CPT 22802 is approximately equivalent to CPT 23472 (*A rthroplasty with glenoid and proximal humeral replacement (eg, total shoulder)*) plus the work of an autograft. Also, the critical intraoperative anatomical alignment for CPT 23802 is more difficult and intensive.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This RVW compares well with the RVW for the key reference services (CPT 23472 and 27284) and takes into account their similarities in work.

The patient requiring CPT 23802 has become more complex. New imaging technology has led to an increase in the number of complex patients presenting for this service who are post-traumatic or represent failed total joint with a lot of bone loss, as opposed to patients who are post-infection (not as complex).

Public Comments

05-Jul-95

Code: 23802

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Arthrodesis, shoulder joint; with primary autogenous graft (includes obtaining graft)

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP

Trends Analysis – Beneficiary Information:

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
23802	29	26	-5.3

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
23802	93.1	92.3	-0.4

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
23802	orthopedic surgery	100

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
23802	AAOS		090	090	14.01	14.67	1.05	14.67

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
23802									

Public Comments

05-Jul-95

AAOS	14.67	14.67	1.05	1.00	1.00	1.00	.
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Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
23802								
AAOS	090	14.01		33	*	165		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
23802									
AAOS	*	1.0	*	10	5.0	*	10	0.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
23802									
AAOS	*	10			14.67	or	3		0.052

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27147 Global Period: 090 1995 RVW: 17.58 Recommended RVW: 19.70
Accepted by Workgroup

CPT Descriptor: Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18-month-old with a subluxated hip is treated with an open reduction and iliac osteotomy.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of X-rays, ultrasound studies; preoperative arthrogram; review of preoperative plan, lab work; review of patient history; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; ordering preoperative blood in bank; arranging for intraoperative X-ray to check pin and hip location; ordering cell saver; positioning patient on OR table and applying peroneal sticky drape; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: An anterior Smith-Peterson type incision is made from several inches back on the iliac crest down over the anterior thigh. After dissecting through the soft tissues and cauterizing bleeders, the anterior fascia is opened to identify the anterior-superior iliac spine and the origin of the sartorius muscle. Our first effort is to identify the lateral femoral cutaneous nerve which exits the pelvis just medial to the ASIS. The section is carried out medial to the sartorius until the nerve is identified. A vessel loop is passed around the nerve, and it is then dissected distally, taking care to preserve its several branches. Once the nerve is retracted out of the operative site, the origin of the sartorius can be taken down with a small piece of cartilage to facilitate reattachment. The sartorius muscle is then dissected distally by several inches in order to expose the anterior capsule of the hip joint as well as the anterior-inferior iliac spine. On that bony prominence, we can identify the origin of the rectus femoris with its straight and reflected heads. These are identified and also removed with a small piece of cartilage to facilitate reattachment. This muscle is also dissected distally. Both muscles are wrapped in a moist sponge in order to protect from tissue drying. The hip is then flexed about 30 degrees and dissection is carried down along the lateral wall of the iliopsoas muscle, following it down to its lesser trochanteric insertion. Careful dissection in this area allows for the identification of the psoas tendon attachment to this bony prominence. That tendinous insertion is released sharply with a scalpel under direct vision, leaving the iliacus muscle insertion intact. The iliac apophysis is then split along the crest for several inches, dividing the cartilaginous apophysis in half. A Cobb elevator is then used to dissect subperiosteally, exposing the inner and outer tables of the iliac crest all the way to the sciatic notch posteriorly. The dissection is also carried down along the anterior segment of the ilium to the anterior-inferior iliac spine, freeing all soft tissues from their attachment in those areas. With the use of a moderately long right angle clamp, the periosteal attachments to the sciatic notch are teased away in order to allow passage of a Gigli saw. The handles are attached to the Gigli saw and tissue protectors are provided medially and laterally while the saw is used to cut from the sciatic notch out to the anterior-inferior iliac spine. Care must be taken to be sure that the cut of the saw is transverse to the body axis alignment. Next a wedge of bone is outlined, including from the anterior-inferior iliac spine posteriorly to the mid portion of the iliac crest. An oscillating saw is then used to make a transverse cut from the outer to the inner table after having grasped firmly the future bone graft with a towel clamp. The bone graft itself must be fashioned to have a wedge shape with linear edges which are transverse to the inner and outer table of the graft. Lewin bone holding forceps are used to grasp into the remaining portions of the ilium above and below the site of the osteotomy made by the Gigli saw.

Intraoperative work (continued):

The lower portion of the ilium is pulled laterally and inferiorly in order to open up a gap while leaving the osteotomy in the sciatic notch essentially closed. A laminectomy spreader can then be applied anteriorly to stretch the additional soft tissues to allow for full opening of the osteotomy anteriorly. The bone graft is then inserted after having been grasped with a large, straight Kocher clamp. Again, care must be taken to make the placement of the graft parallel with the long axis of the body. Traction from the clamps can then be released to allow the graft to be held in place by compression. The two smooth Kirschner wires .062 in diameter are then inserted through the proximal ilium, across the graft and into the superior part of the acetabulum. Once this has been accomplished, care must be taken to be sure that the pins do not pass into the acetabulum by measuring with a comparable pin and by fluoroscopic or radiographic assessment. The wires are bent over the top of the iliac crest and cut off for later retrieval. This completes the innominate osteotomy procedure. It must be noted that a bone graft is ALWAYS done and is an integral part of the innominate osteotomy.

For open reduction of the hip, the soft tissues surrounding the hip capsule are dissected superiorly, anteriorly, and inferiorly. A scalpel is then carefully used to cut along the edge of the acetabulum, leaving a 2-3 mm. cuff of capsular tissue for future repair. Once the capsule is opened and the femoral head visualized, a skid can be introduced under the capsule and the dissection cut down onto the metal protector to avoid damaging the femoral head. This is done down to the inferior portion of the capsule and up around to the mid portion of the superior aspect of the capsule. A transverse incision is then made along the femoral neck from the midpoint of the previous capsular incision, This then creates a T-shaped incision that allows the two flaps to be opened and the femoral head to be visualized. It can then be partially displaced into the incision so that the ligamentum teres can be identified and carefully dissected off of the femoral head. This then allows the femoral head to be moved further out of the acetabulum and the intra-acetabular attachment of the ligamentum teres can then be cut. Additionally, the limbus, if folded, can be dissected free and the transverse acetabular ligament inferiorly in the acetabulum is released to facilitate reduction of the femoral head. Once the femoral head is reduced, the superior triangular flap of the capsule can be removed so that a reduction capsuloplasty repair can be performed. Once the flap is removed, then the remaining capsular edges are sutured together, using number one non-absorbable suture in an interrupted fashion. Usually half a dozen stitches are necessary from the superior portion of the acetabulum down over the anterior part of the femoral head. The inferior triangular flap is then sutured over top of the previous incision in a pants-over-vest arrangement to further secure the capsular repair. Once the capsular repair is started, the femoral head must be held into the joint by positioning the hip in flexion, abduction and internal rotation, usually about 25 degrees for each position.

After completing the pelvic osteotomy and/or open reduction of the hip, the insertion of the rectus femoral is reattached to the anterior-inferior iliac spine. This involves passing a heavy suture through the bone after a hole has been placed through which the suture can be passed. A number one non-absorbable suture is used to tie the tendon back to its origin. Next the sartorius is reattached to the ilium above that. The anterior-superior iliac spine has been used as part of the wedge graft, so the sartorius is merely attached to the upper edge of the ilium through a similar mechanism of drilling a hole and passing a number one suture through that hole before tying it. The vessel loop around the lateral femoral cutaneous nerve is removed and the nerve is allowed to lie back in its bed. The superficial fascia layer is then approximated with 2.0 Vicryl suture. The subcutaneous tissues are closed by multiple interrupted sutures of 3.0 Vicryl and a running subcuticular 4.0 Vicryl suture is the final closure.

Postoperative work begins after skin closure in the operating room and includes application of dressing and postoperative spica cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring lab studies, postoperative x-rays, vital signs, etc.; care and removal of postoperative drain; adjustments of cast (trim and/or repair); supervision of postoperative physical therapy- review progress and adjust ; ordering and reviewing postoperative x-rays; evaluating leg length; ordering shoe lift as needed ; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay, instructions for continuing care, including home health nursing, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, internal fixation pins and cast changes; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America

Survey n: 134
Response: 34
Rate %: 25%

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
					total min	# visits	total min	# visits	total min	# visits
low	16.00		120							
25th%	18.00		143							
med	19.70	83	180	40	0	0	50	3	60	4
75th%	21.67		210							
high	25.92		300							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27147:	57	161	35	0	0	100	10	50	5
Harvard 27158:	62	172	30	0	0	110	10	63	5

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
18.10	27158	Osteotomy, pelvis, bilateral (eg, for congenital malformation)
16.20	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
18.10	090	27158	Osteotomy, pelvis, bilateral (eg, for congenital malformation)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27147 (*Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip*) is a similar bony procedure, but is more work and involves more time than CPT 27158 (*Osteotomy, pelvis, bilateral (eg, for congenital malformation)*) because CPT 27147 involves more soft tissue repair, special repair of the capsule, open hip reduction, and includes application of an exacting spica cast. Those patients requiring CPT 27147 generally have a lower tolerance for blood loss, which corresponds to a greater intensity intraoperatively.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The current value for CPT 27147 represents an anomaly in the Medicare Fee Schedule. Although the times are similar to CPT 27158, the intensity and complexity of work are higher, so that total work for CPT 27147 is more than CPT 27158, however, the current RVW is less.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation, along with the survey respondents that are "fit-to-rate" this service that CPT 27147 is more work than CPT 27158. The survey median RVW is recommended to appropriately value this service and correct an anomaly.

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27147								
AAOS	17.58	17.58	1.06	1.00	1.00	1.00	28.20	25

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
27147								
AAOS	090	16.61		32	*	161		50

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27147									
AAOS	*	1.0	*	10	10.0	*	10	0.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27147									
AAOS	*	10		28.20	17.58	or	3		0.056

Public Comments

30-Jun-95

Code: 27147

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27147	59	12	-54.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27147	98.3	66.7	-15.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27147	group practices	16.7
	orthopedic surgery	83.3

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27147							
AAOS		090	090	16.61	17.58	1.06	17.58

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27146 Global Period: 090 1995 RVW: 13.72 Recommended RVW: 16.55
Workgroup Recommended New Value: 16.90

CPT Descriptor: Osteotomy, iliac, acetabular or innominate bone;

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4-year-old girl has an iliac osteotomy to correct a residual acetabular dysplasia after undergoing closed reduction of a developmental hip dislocation soon after birth.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of X-rays, CT scan with 3-D reconstruction tape; review of operative plan and lab work; review of patient history; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; arranging for intraoperative X-ray to check pin placement, cell saver; advise re: intraoperative drugs; position patient on OR table; apply peroneal sticky drape; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite

Intraoperative work: An anterior Smith-Peterson type incision is made from several inches back on the iliac crest down over the anterior thigh. After dissecting through the soft tissues and cauterizing bleeders, the anterior fascia is opened to identify the anterior-superior iliac spine and the origin of the sartorius muscle. Our first effort is to identify the lateral femoral cutaneous nerve which exits the pelvis just medial to the ASIS. The section is carried out medial to the sartorius until the nerve is identified. A vessel loop is passed around the nerve, and it is then dissected distally, taking care to preserve its several branches. Once the nerve is retracted out of the operative site, the origin of the sartorius can be taken down with a small piece of cartilage to facilitate reattachment. The sartorius muscle is then dissected distally by several inches in order to expose the anterior capsule of the hip joint as well as the anterior-inferior iliac spine. On that bony prominence, we can identify the origin of the rectus femoris with its straight and reflected heads. These are identified and also removed with a small piece of cartilage to facilitate reattachment. This muscle is also dissected distally. Both muscles are wrapped in a moist sponge in order to protect from tissue drying. The hip is then flexed about 30 degrees and dissection is carried down along the lateral wall of the iliopsoas muscle, following it down to its lesser trochanteric insertion. Careful dissection in this area allows for the identification of the psoas tendon attachment to this bony prominence. That tendinous insertion is released sharply with a scalpel under direct vision, leaving the iliacus muscle insertion intact. The iliac apophysis is then split along the crest for several inches, dividing the cartilaginous apophysis in half. A Cobb elevator is then used to dissect subperiosteally, exposing the inner and out tables of the iliac crest all the way to the sciatic notch posteriorly. The dissection is also carried down along the anterior segment of the ilium to the anterior-inferior iliac spine, freeing all soft tissues from their attachment in those areas. With the use of a moderately long right angle clamp, The periosteal attachments to the sciatic notch are teased away in order to allow passage of a Gigli saw. The handles are attached to the Gigli saw and tissue protectors are provided medially and laterally while the saw is used to cut from the sciatic notch out to the anterior-inferior iliac spine. Care must be taken to be sure that the cut of the saw is transverse to the body axis alignment. Next a wedge of bone is outlined, including from the anterior-inferior iliac spine posteriorly to the mid portion of the iliac crest, An oscillating saw is then used to make a transverse cut from the outer to the inner table after having grasped firmly the future bone graft with a towel clamp. The bone graft itself must be fashioned to have a wedge shape with linear edges which are transverse to the inner and outer table of the graft. Lewin bone holding forceps are used to grasp into the remaining portions of the ilium above and below the site of the osteotomy made by the Gigli saw.

Intraoperative work (continued)

The lower portion of the ilium is pulled laterally and inferiorly in order to open up a gap while leaving the osteotomy in the sciatic notch essentially closed. A laminectomy spreader can then be applied anteriorly to stretch the additional soft tissues to allow for full opening of the osteotomy anteriorly. The bone graft is then inserted after having been grasped with a large, straight Kocher clamp. Again, care must be taken to make the placement of the graft parallel with the long axis of the body. Traction from the clamps can then be released to allow the graft to be held in place by compression. The two smooth Kirschner wires .062 in diameter are then inserted through the proximal ilium, across the graft and into the superior part of the acetabulum. Once this has been accomplished, care must be taken to be sure that the pins do not pass into the acetabulum by measuring with a comparable pin and by fluoroscopic or radiographic assessment. The wires are bent over the top of the iliac crest and cut off for later retrieval. The superficial fascia layer is then approximated with 2.0 Vicryl suture. The subcutaneous tissues are closed by multiple interrupted sutures of 3.0 Vicryl and a running subcuticular 4.0 Vicryl suture is the final closure. It must be noted that a bone graft is ALWAYS done and is an integral part of the innominate osteotomy.

Postoperative work begins after skin closure in the operating room and includes application of dressing and postoperative spica cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring lab studies, postoperative x-rays, vital signs, etc.; care and removal of postoperative drain; adjustments of cast (trim and/or repair); supervision of postoperative physical therapy- review progress and adjust ; ordering and reviewing postoperative x-rays; evaluating leg length; ordering shoe lift as needed ; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay, instructions for continuing care, including home health nursing, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, internal fixation pins and cast changes; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America

Survey n:	134	RVW	PRE total min	INTRA total min	POST						
Response:	34				Day 1 total min	ICU		Hosp. - Other		Office	
Rate %:	25%					total min	# visits	total min	# visits	total min	# visits
low	10.00		80								
25th%	14.85		120								
med	16.55	83	150	40	0	0	45	3	60	4	
75th%	18.00		180								
high	22.00		240								

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27146:	50	135	31	0	0	55	5.5	45	4.5
Harvard 27165:	55	147	28	0	0	99	9	60	5

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
18.10	27158	Osteotomy, pelvis, bilateral (eg, for congenital malformation)
16.20	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
16.20	090	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27165 (*Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast*) and CPT 27146 (*Osteotomy, iliac, acetabular or innominate bone;*) represent similar osteotomies, only the former is below the hip and the latter is above the hip. The intraoperative time is the same for both.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT 27146 and CPT 27165 are similar procedures that require similar time and work and, as such, should have similar RVWs. This recommended RVW places a value on CPT 27146 that is "relative" to CPT 27165.

Public Comments

05-Jul-95

Code: 27146

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Osteotomy, iliac, acetabular or innominate bone;

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27146	75	0	0	25	25	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27146	35	47	15.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27146	94.3	95.7	0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27146	anesthesiology	4.3
	general surgery	10.6
	orthopedic surgery	80.9
	plastic surgery	4.3

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27146							
AAOS		090	090	12.96	13.72	1.06	13.72

Public Comments

05-Jul-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27146								
AAOS	13.72	13.72	1.06	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27146								
AAOS	090	12.96		29	*	132		42

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27146									
AAOS	*	1.0	*	10	5.5	*	10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27146									
AAOS	*	10		.	13.72	or	3		0.057

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27151 Global Period: 090 1995 RVW: 18.58 Recommended RVW: 21.50
Accepted by Workgroup

CPT Descriptor: Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 6-year-old with residual hip dislocation of the hip undergoes an open reduction, femoral shortening, and iliac osteotomy.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of all preoperative x-rays, scans, CT or MRI including 3-D studies; review preoperative plan; lab work; patient history, especially allergies, medical problems and family history; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; ordering preoperative blood in bank; arranging for intraoperative x-rays and C-arm; ordering cell saver; advising anesthesia re: intraoperative rugs (antibiotics); positioning patient on OR table using bean bag; applying peroneal sticky drape; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite. A GU Foley catheter must be available if the case is expected to take over three hours.

Intraoperative work: An anterior Smith-Peterson type incision is made from several inches back on the iliac crest down over the anterior thigh. After dissecting through the soft tissues and cauterizing bleeders, the anterior fascia is opened to identify the anterior-superior iliac spine and the origin of the sartorius muscle. Our first effort is to identify the lateral femoral cutaneous nerve which exits the pelvis just medial to the ASIS. The section is carried out medial to the sartorius until the nerve is identified. A vessel loop is passed around the nerve, and it is then dissected distally, taking care to preserve its several branches. Once the nerve is retracted out of the operative site, the origin of the sartorius can be taken down with a small piece of cartilage to facilitate reattachment. The sartorius muscle is then dissected distally by several inches in order to expose the anterior capsule of the hip joint as well as the anterior-inferior iliac spine. On that bony prominence, we can identify the origin of the rectus femorus with its straight and reflected heads. These are identified and also removed with a small piece of cartilage to facilitate reattachment. This muscle is also dissected distally. Both muscles are wrapped in a moist sponge in order to protect from tissue drying. The hip is then flexed about 30 degrees and dissection is carried down along the lateral wall of the iliopsoas muscle, following it down to its lesser trochanteric insertion. Careful dissection in this area allows for the identification of the psoas tendon attachment to this bony prominence. That tendinous insertion is released sharply with a scalpel under direct vision, leaving the iliacus muscle insertion intact. The iliac apophysis is then split along the crest for several inches, dividing the cartilaginous apophysis in half. A Cobb elevator is then used to dissect subperiosteally, exposing the inner and out tables of the iliac crest all the way to the sciatic notch posteriorly. The dissection is also carried down along the anterior segment of the ilium to the anterior-inferior iliac spine, freeing all soft tissues from their attachment in those areas. With the use of a moderately long right angle clamp, The periosteal attachments to the sciatic notch are teased away in order to allow passage of a Gigli saw. The handles are attached to the Gigli saw and tissue protectors are provided medially and laterally while the saw is used to cut from the sciatic notch out to the anterior-inferior iliac spine. Care must be taken to be sure that the cut of the saw is transverse to the body axis alignment. Next a wedge of bone is outlined, including from the anterior-inferior iliac spine posteriorly to the mid portion of the iliac crest. An oscillating saw is then used to make a transverse cut from the outer to the inner table after having grasped firmly the future bone graft with a towel clamp.

Intraoperative work (continued):

The bone graft itself must be fashioned to have a wedge shape with linear edges which are transverse to the inner and outer table of the graft. Lewin bone holding forceps are used to grasp into the remaining portions of the ilium above and below the site of the osteotomy made by the Gigli saw. The lower portion of the ilium is pulled laterally and inferiorly in order to open up a gap while leaving the osteotomy in the sciatic notch essentially closed. A laminectomy spreader can then be applied anteriorly to stretch the additional soft tissues to allow for full opening of the osteotomy anteriorly. The bone graft is then inserted after having been grasped with a large, straight Kocher clamp. Again, care must be taken to make the placement of the graft parallel with the long axis of the body. Traction from the clamps can then be released to allow the graft to be held in place by compression. The two smooth Kirschner wires .062 in diameter are then inserted through the proximal ilium, across the graft and into the superior part of the acetabulum. Once this has been accomplished, care must be taken to be sure that the pins do not pass into the acetabulum by measuring with a comparable pin and by fluoroscopic or radiographic assessment. The wires are bent over the top of the iliac crest and cut off for later retrieval. This completes the innominate osteotomy procedure. It must be noted that a bone graft is ALWAYS done and is an integral part of the innominate osteotomy.

For the femoral osteotomy, a separate longitudinal incision is made from the greater trochanter along the lateral thigh for several inches. The dissection is carried down through the subcutaneous tissues to the fascia lata. Care is taken to dissect the fatty tissues off of the fascia lata to facilitate later closure. The fascia lata is then opened in the mid substance longitudinally from the greater trochanter distally for a total of 4-5 inches. This then exposes the fascia of the vastus lateralis which is dissected free from the fascia lata and this fascia layer is opened posteriorly in order to come in behind the vastus lateralis to reach the lateral border of the thigh. This reduces the chance for denervation of the posterior musculature. A periosteal incision is made and the periosteum stripped from the outer edge of the greater trochanter distally. Bennett retractors are then used to hold the vastus lateralis muscle up anteriorly. A Scott-McCracken periosteal elevator is then used to release the linea aspera fascial attachment so that a Bennett retractor can be placed around the femur posteriorly. Then, under C-arm control, a guide wire is drilled up the femoral neck from the lateral femoral shaft, but shy of the proximal femoral physis. The guide wire position is confirmed to be central on both AP and frog lateral views. A cannulated drill is then drilled over the guide wire to penetrate the outer cortex. The screw tap is then used to set the threads for the lag screw that will be placed up the femoral neck. The appropriate length of screw is selected and inserted. The transverse osteotomy is then cut now 5 mm. below the inferior penetration of the cortex by the lag screw. Another transverse osteotomy a centimeter below that is made in order to remove a centimeter of length from the femur. A 2-inch three hole side plate (or a 3-inch 4 hole side plate in the older child) is used with a 140 degree neck/shaft angle, to attach to the lag screw. The side plate is then clamped to the femoral shaft by a verbouge clamp. Care is taken to preserve rotational alignment, maintaining 20-30 degrees of anteversion in the femoral neck with regard to the coronal axis of the femur, drills are then used to drill through the holes in the plate. A depth gauge is used to select the proper size screws and they are placed into the screw holes after tapping the screw threads. The gap where the cortex section was resected is closed before securing the side plate to the shaft. A hemovac drain is then placed after irrigation of the wound with a Bacitracin irrigation. The fascia of the vastus lateralis is repaired, as is the fascia lata, with O-Vicryl suture. The soft tissue is approximated with 2.0 Vicryl suture and the running subcuticular Vicryl closure is the final skin closure.

Postoperative work begins after skin closure in the operating room and includes application of dressing and spica cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring lab studies; postoperative x-rays; vital signs, etc.; care and removal of postoperative drains; adjustments of cast (trim and/or repair); supervision of nursing care in hospital, postoperative physical therapy--review progress and adjust; ordering and reviewing postoperative x-rays, evaluation of leg length--order shoe lift as needed; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay, instructions for continuing care, including coordination of home health nursing, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, pin removal and cast changes; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. Ordering of physical therapy at an appropriate time during healing to allow weight bearing depending on the degree of bone healing on X-ray. Direction is given to physical therapy to recover range of motion of the affected hip.

SURVEY DATA:

Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America

Survey n:134

Response:34

Rate %:25%

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
					total min	# visits	total min	# visits	total min	# visits
low	15.00		100							
25th%	19.13		180							
med	21.50	83	210	40	0	0	60	4	60	4
75th%	24.23		240							
high	35.00		300							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27151:	59	182	35	0	0	105	10	55	5.5
Harvard 27146:	54	132	27	0	0	59	5	56	5
Harvard 27165:	55	147	28	0	0	99	9	60	5

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
18.10	27158	Osteotomy, pelvis, bilateral (eg, for congenital malformation)
16.20	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
(13.72/16.55)*	090	27146	Osteotomy, iliac, acetabular or innominate bone;
16.20	090	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

*Note: this procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 13.72 to 16.55, is being presented.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27151 (*Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy*) represents the sum of 100% of CPT 27146 (*Osteotomy, iliac, acetabular or innominate bone;*) plus the intraoperative portion of CPT 27165 (*Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast*). These procedures are performed through separate incisions.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT 27151 represents the sum of CPT 27146 plus the intraoperative portion of CPT 27165. These procedures are performed through separate incisions. Using the multiple procedure rule, this equates to 24.65 [16.55 + (16.20 x 50%)]. Although this value is higher than the survey median, the median RVW is recommended

Public Comments

05-Jul-95

Code: 27151

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

--

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27151	100	100	100	100	0	0	0	.

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27151	35	36	1.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27151	91.4	83.3	-4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27151	orthopedic surgery	100

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27151	AAOS		090	090	17.53	18.58	1.06	18.58

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27151								
AAOS	18.58	18.58	1.06	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27151								
AAOS	090	17.53		33	*	182		51

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27151									
AAOS	*	1.0	*	10	10.5	*	10	0.0	5.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27151									
AAOS	*	10			18.58	or	3		0.053

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27156 Global Period: 090 1995 RVW: 20.16 Recommended RVW: 23.62
Accepted by Workgroup

CPT Descriptor: Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2-year-old with a developmental dislocation of the hip undergoes a femoral shortening, open reduction, and iliac osteotomy.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of all preoperative-rays, scans, CT or MRI including 3-D studies; review preoperative plan, lab work; patient history, esp. allergies, medical problems, family history; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes scrubbing; ordering blood in bank; arranging for intraoperative X-ray and/or C-arm; order cell saver; advise anesthesia re: intraoperative drugs, antibiotics; positioning the patient on OR table using bean bag; apply peroneal sticky drape; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: An anterior Smith-Peterson type incision is made from several inches back on the iliac crest down over the anterior thigh. After dissecting through the soft tissues and cauterizing bleeders, the anterior fascia is opened to identify the anterior-superior iliac spine and the origin of the sartorius muscle. Our first effort is to identify the lateral femoral cutaneous nerve which exits the pelvis just medial to the ASIS. The section is carried out medial to the sartorius until the nerve is identified. A vessel loop is passed around the nerve, and it is then dissected distally, taking care to preserve its several branches. Once the nerve is retracted out of the operative site the origin of the sartorius can be taken down with a small piece of cartilage to facilitate reattachment. The sartorius muscle is then dissected distally by several inches in order to expose the anterior capsule of the hip joint as well as the anterior-inferior iliac spine. On that bony prominence, we can identify the origin of the rectus femorus with its straight and reflected heads. These are identified and also removed with a small piece of cartilage to facilitate reattachment. This muscle is also dissected distally. Both muscles are wrapped in a moist sponge in order to protect from tissue drying. The hip is then flexed about 30 degrees and dissection is carried down along the lateral wall of the iliopsoas muscle, following it down to its lesser trochanteric insertion. Careful dissection in this area allows for the identification of the psoas tendon attachment to this bony prominence. That tendinous insertion is released sharply with a scalpel under direct vision, leaving the iliacus muscle insertion intact. The iliac apophysis is then split along the crest for several inches, dividing the cartilaginous apophysis in half, A Cobb elevator is then used to dissect subperiosteally, exposing the inner and outer tables of the iliac crest all the way to the sciatic notch posteriorly. The dissection is also carried down along the anterior segment of the ilium to the anterior-inferior iliac spine, freeing all soft tissues from their attachment in those areas. With the use of a moderately long right angle clamp, The periosteal attachments to the sciatic notch are teased away in order to allow passage of a Gigli saw. The handles are attached to the Gigli saw and tissue protectors are provided medially and laterally while the saw is used to cut from the sciatic notch out to the anterior-inferior iliac spine. Care must be taken to be sure that the cut of the saw is transverse to the body axis alignment. Next a wedge of bone is outlined, including from the anterior-inferior iliac spine posteriorly to the mid portion of the iliac crest. An oscillating saw is then used to make a transverse cut from the outer to the inner table after having grasped firmly the future bone graft with a towel clamp.

Intraoperative work (continued):

The bone graft itself must be fashioned to have a wedge shape with linear edges which are transverse to the inner and outer table of the graft. Lewin bone holding forceps are used to grasp into the remaining portions of the ilium above and below the site of the osteotomy made by the Gigli saw. The lower portion of the ilium is pulled laterally and inferiorly in order to open up a gap while leaving the osteotomy in the sciatic notch essentially closed. A laminectomy spreader can then be applied anteriorly to stretch the additional soft tissues to allow for full opening of the osteotomy anteriorly. The bone graft is then inserted after having been grasped with a large, straight Kocher clamp. Again, care must be taken to make the placement of the graft parallel with the long axis of the body. Traction from the clamps can then be released to allow the graft to be held in place by compression. The two smooth Kirschner wires .062 in diameter are then inserted through the proximal ilium, across the graft and into the superior part of the acetabulum. Once this has been accomplished, care must be taken to be sure that the pins do not pass into the acetabulum by measuring with a comparable pin and by fluoroscopic or radiographic assessment. The wires are bent over the top of the iliac crest and cut off for later retrieval. This completes the innominate osteotomy procedure. It must be noted that a bone graft is ALWAYS done and is an integral part of the innominate osteotomy.

For open reduction of the hip, the soft tissues surrounding the hip capsule are dissected superiorly, anteriorly, and inferiorly. A scalpel is then carefully used to cut along the edge of the acetabulum, leaving a 2-3 mm. cuff of capsular tissue for future repair. Once the capsule is opened and the femoral head visualized, a skid can be introduced under the capsule and the dissection cut down onto the metal protector to avoid damaging the femoral head. This is done down to the inferior portion of the capsule and up around to the mid portion of the superior aspect of the capsule. A transverse incision is then made along the femoral neck from the midpoint of the previous capsular incision. This then creates a T-shaped incision that allows the two flaps to be opened and the femoral head to be visualized. It can then be partially displaced into the incision so that the ligamentum teres can be identified and carefully dissected off of the femoral head. This then allows the femoral head to be moved further out of the acetabulum and the intra-acetabular attachment of the ligamentum teres can then be cut. Additionally, the limbus, if folded, can be dissected free and the transverse acetabular ligament inferiorly in the acetabulum is released to facilitate reduction of the femoral head. Once the femoral head is reduced, the superior triangular flap of the capsule can be removed so that a reduction capsuloplasty repair can be performed. Once the flap is removed, then the remaining capsular edges are sutured together, using number one non-absorbable suture in an interrupted fashion. Usually half a dozen stitches are necessary from the superior portion of the acetabulum down over the anterior part of the femoral head. The inferior triangular flap is then sutured over top of the previous incision in a pants-over-vest arrangement to further secure the capsular repair. Once the capsular repair is started, the femoral head must be held into the joint by positioning the hip in flexion, abduction and internal rotation, usually about 25 degrees for each position,

The femoral osteotomy is performed through a separate longitudinal incision made from the greater trochanter along the lateral thigh for several inches. The dissection is carried down through the subcutaneous tissues to the fascia lata. Care is taken to dissect the fatty tissues off of the fascia lata to facilitate later closure. The fascia lata is then opened in the mid substance longitudinally from the greater trochanter distally for a total of 4-5 inches. This then exposes the fascia of the vastus lateralis which is dissected free from the fascia lata and this fascia layer is opened posteriorly in order to come in behind the vastus lateralis to reach the lateral border of the thigh. This reduces the chance for denervation of the posterior musculature. A periosteal incision is made and the periosteum stripped from the outer edge of the greater trochanter distally. Bennett retractors are then used to hold the vastus laterals muscle up anteriorly. A Scott-McCracken periosteal elevator is then used to release the linea aspera fascial attachment so that a Bennett retractor can be placed around the femur posteriorly. Then, under C-arm control, a guide wire is drilled up the femoral neck from the lateral femoral shaft, but shy of the proximal femoral physis. The guide wire position is confirmed to be central on both AP and frog lateral views. A cannulated drill is then drilled over the guide wire to penetrate the outer cortex. The screw tap is then used to set the threads for the lag screw that will be placed up the femoral neck. The appropriate length of screw is selected and inserted. The transverse osteotomy is then cut now 5 mm. below the inferior penetration of the cortex by the lag screw. Another transverse osteotomy a centimeter below that is made in order to remove a centimeter of length from the femur. A 2-inch three hole side plate (or a 3-inch 4 hole side plate in the older child) is used with a 140 degree neck/shaft angle, to attach to the lag screw. The side plate is then clamped to the femoral shaft by a verbouge clamp. Care is taken to preserve rotational alignment, maintaining 20-30 degrees of anteversion in the femoral neck with regard to the coronal axis of the femur. Drills are then used to drill through the holes in the plate. A depth gauge is used to select the proper size screws and they are placed into the screw holes after tapping the screw threads. The gap where the cortex section was resected is closed before securing the side plate to the shaft. A hemovac drain is then placed after irrigation of the wound with a Bacitracin irrigation and the wound closed in layers.

Intraoperative work (continued):

After completing the pelvic osteotomy and/or open reduction of the hip, the insertion of the rectus femoral is reattached to the anterior-inferior iliac spine. This involves passing a heavy suture through the bone after a hole has been placed through which the suture can be passed. A number one non-absorbable suture is used to tie the tendon back to its origin. Next the sartorius is reattached to the ilium above that. The anterior-superior iliac spine has been used as part of the wedge graft, so the sartorius is merely attached to the upper edge of the ilium through a similar mechanism of drilling a hole and passing a number one suture through that hole before tying it. The vessel loop around the lateral femoral cutaneous nerve is removed and the nerve is allowed to lie back in its bed. The superficial fascia layer is then approximated with 2.0 Vicryl suture. The subcutaneous tissues are closed by multiple interrupted sutures of 3.0 Vicryl and a running subcuticular 4.0 Vicryl suture is the final closure.

Postoperative work begins after skin closure in the operating room and includes application of dressing and postoperative spica cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring lab studies; postoperative x-rays; care and removal of drains; adjustments of cast (trim and/or repair); physical therapy--review progress and adjust program; ordering and reviewing x-rays; evaluation of leg length post-cast--order shoe lift as needed ; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay, instructions for continuing care, including home health care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, removal of pins and cast changes; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. Ordering of physical therapy at an appropriate time during healing to allow weight bearing depending on the degree of bone healing on X-ray. Direction is given to physical therapy to recover range of motion of the affected hip.

SURVEY DATA:

Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America

Survey n:134

Response:34

Rate %:25%

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
					total min	# visits	total min	# visits	total min	# visits
low	16.00		150							
25th%	20.00		210							
med	23.62	83	225	40	0	0	60	4	60	4
75th%	26.00		240							
high	32.58		360							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27156:	61	210	35	0	0	105	10	55	5.5
Harvard 27147:	57	161	35	0	0	100	10	50	5
Harvard 27165:	55	147	28	0	0	99	9	60	5

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
18.10	27158	Osteotomy, pelvis, bilateral (eg, for congenital malformation)
16.20	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
(17.58/19.70)*	090	27147	Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip
16.20	090	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

*Note: this procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 17.58 to 19.70, is being presented.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27156 (Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip) represents the sum of 100% of CPT 27147 (*Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip*) plus the intraoperative portion of CPT 27165 (*Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast*). These procedures are performed through separate incisions.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT 27156 represents the sum of CPT 27147 plus the intraoperative portion of CPT 27165. These procedures are performed through separate incisions. Using the multiple procedure rule, this equates to 27.80 [19.70 + (16.20 x 50%)]. Although this value is higher than the survey median, the median RVW is recommended

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27454 Global Period: 090 1995 RVW: 12.26 Recommended RVW: 16.90
Workgroup Recommended New Value: 16.55

CPT Descriptor: Osteotomy, multiple, femoral shaft, with realignment on intramedullary rod
(Sofield type procedure)

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A child with osteogenesis imperfecta and bowing of the femur as a result of many previous fractures undergoes multiple osteotomies and intra-medullary fixation (Sofield technique) to straighten the femur.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to preoperative radiographic measurements and hematologic status; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; ordering implants such as Rush rods; arranging for intraoperative radiographic table, blood; positioning the patient in 45 degree lateral decubitus position; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: The entire shaft of the femur is then exposed through a long transverse skin incision. The fascia lata is divided and the vastus lateralis muscle mobilized anteriorly. The perforating vessels are coagulated or ligated as necessary. Multiple osteotomies are performed to allow for complete correction of the angular deformity. The piriformis fossa at the base of the femoral neck is exposed proximally by dissecting through the gluteus medius muscle. A drill is used to create a starting hole. This hole may also be created in a retrograde fashion with the Rush rod or drill if necessary. A Rush rod of appropriate length and diameter is then selected. The rod should be of sufficient diameter to fill the medullary canal of the osteotomy segments. It should terminate just proximal to the distal femoral epiphysis. The rod is advanced distally and the bone is usually of such softness that the segments do not require drilling. They are threaded over the rod in a napkin ring manner. If soft tissues become tight due to the straightening of the shaft of the femur one or two bone segments may be removed. The hooked end of the rush rod is placed over the greater trochanter. This allows easy identification and removal for exchange rodding in the future. After rod insertion its position is checked with anteroposterior and lateral radiographs. The wound typically is drained. The fascia lata, subcutaneous tissue and skin are closed in layers. Steri-strips are applied to the skin edges.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and well padded hip spica. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status and hematologic status; care and removal of Hemovac drain; adjustments of cast; ordering and reviewing postoperative radiographs; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; removal of cast when X-rays done at each office visit demonstrate bone healing; ordering new orthoses (braces to protect the extremity); ordering of physical therapy after bone healing and removal of the cast to restore joint range of motion; laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America

Survey n:	134	PRE	INTRA	POST							
Response:	32			total min	total min	Day 1 total min	ICU		Hosp. - Other		Office
Rate %:	24%	RVW	RVW				RVW	total min	# visits	total min	# visits
	low	13.00		80							
	25th%	15.75		120							
	med	16.90	60	150	30	0	0	50	4	60	4
	75th%	18.00		180							
	high	24.20		240							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27454:	50	133	31	0	0	45	4.5	45	4.5
Harvard 24410:	58	129	29	0	0	17	2	59	5
Harvard 27165:	55	147	28	0	0	99	9	60	5

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
14.28	24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
16.20	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
14.28	090	24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
16.20	090	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 24410 (*Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)*) is less work than CPT 27454 (*Osteotomy, multiple, femoral shaft, with realignment on intramedullary rod (Sofield type procedure)*) because exposure is required and more osteotomies are necessary on the larger femur bone.

CPT 27165 (*Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast*) is slightly less work than CPT 27454 which requires additional exposure and has the potential for greater blood loss.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT 27454 is slightly more work than CPT 27165 and more than CPT 24410, as discussed in the key reference comparison section above. The survey median RVW is recommended because it appropriately places the value of CPT 27454 "relative" to CPT 27165 and CPT 24410.

Public Comments

05-Jul-95

Code: 27454

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Osteotomy, multiple, femoral shaft, with realignment on intramedullary rod (Sofield type procedure)

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27454	50	50	0	100	0	0	0	0

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
27454	65	30	-32.1

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27454	90.8	66.7	-12.1

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
27454	emergency medicine	6.7
	orthopedic surgery	93.3

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27454							
	AAOS	090	090	11.92	12.26	1.03	12.26

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27454								
AAOS	12.26	12.26	1.03	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27454								
AAOS	090	11.92		30	*	133		41

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27454									
AAOS	*	1.0	*	10	4.5	*	10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
27454									
AAOS	*	10			12.26	or	3		0.052

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27712 Global Period: 090 1995 RVW: 11.81 Recommended RVW: 16.00
Workgroup Recommended New Value: 13.20

CPT Descriptor: Osteotomy; multiple, with realignment on intramedullary rod (Sofield type procedure)

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A child with osteogenesis imperfecta and bowing of the leg as a result of many previous fractures undergoes multiple osteotomies and intra-medullary fixation (Sofield technique) to straighten the tibia.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to preoperative radiographic measurements, hematologic status; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes scrubbing; ordering implants such as Rush rods; arranging for intraoperative radiographic table, blood; positioning the patient supine or 45 degree lateral decubitus; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: If only the tibia is to be rodded, it is possible to use a pneumatic tourniquet about the upper thigh, but care must be taken to avoid femoral shaft fractures. The tibia is exposed through a long anterior skin incision. Subperiosteal stripping may be attempted but is difficult due to the stiffness of the bone. The fascia of the anterior compartment must be completely released to prevent a possible postoperative compartment syndrome. The fibula may need to be exposed through a second lateral incision and above the lateral compartment muscles. Osteotomies or osteoclasis is performed but no rod is inserted. The knee joint is open through a medial parapatellar incision. With the knee held in the flexed position a drill hole is placed through the articular surface of the knee just anterior to the anterior tibial spine. Multiple tibial osteotomies are performed to allow for straightening. A Rush rod of appropriate diameter and length is then selected. The rod is advanced through the proximal drill hole and each of the osteotomy segments is passed over the rod. The rod should terminate just above the distal tibial epiphysis. The hooked end of the rod overlaps the tibial tuberosity proximally. Once the rod is inserted final alignment is assessed with anteroposterior and lateral radiographs. If these are acceptable the wounds are then closed in layers. The wound may be drained if necessary. The periosteum, (but not the fascia of the anterior compartment), subcutaneous tissue and skin are closed in layers. Steri strips are applied to the skin edges. Of particular importance in this intraoperative portion of the procedure is achieving perfect alignment of the postoperative tibia in relation to the knee and ankle joints for proper weight bearing.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and a long leg cast or in heavy patients a hip spica cast may be used. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status and hematologic status; care and removal of Hemovac drain; adjustments of cast; ordering and reviewing postoperative radiographs; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; removal of cast when X-rays done at each office visit demonstrate bone healing; ordering new orthoses (braces to protect the extremity); ordering of physical therapy after bone healing and removal of the cast to restore joint range of motion; laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America

Survey n:	134	PRE	INTRA	POST							
Response:	32			total min	total min	Day 1 total min	ICU		Hosp. - Other		Office
Rate %:	24%	RVW	RVW				RVW	total min	# visits	total min	# visits	total min	# visits
	low	12.00		75							
	25th%	14.45		120							
	med	16.00	60	120	30	0	0	45	4	68	4
	75th%	17.63		173							
	high	20.00		240							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27712:	50	119	30	0	0	65	6.5	45	4.5
Harvard 24410:	58	129	29	0	0	17	2	59	5
Harvard 27165:	55	147	28	0	0	99	9	60	5

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
14.28	24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
16.20	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
14.28	090	24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
16.20	090	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 24410 (*Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)*) is less work than CPT 27712 (*Osteotomy; multiple, with realignment on intramedullary rod (Sofield type procedure)*) because a second incision must be made in CPT 27712 to osteotomize the fibula in order to allow correction of the tibia. More osteotomy cuts are frequently necessary with CPT 27712 since the alignment of the postoperative tibia for proper weight bearing is more critical than with CPT 24410.

CPT 24410 demands the knee joint be widely exposed, whereas CPT 27712 needs no joint exposure.

CPT 27165 (*Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast*) is more intense than CPT 27712 because of the potential of greater blood loss, but less work because of a more limited exposure, lack of arthrotomy and single osteotomy (but a more exacting osteotomy). The bone of 27165 is considerably easier to work with than soft osteogenesis imperfecta bone of CPT 27712.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Although CPT 27712 involves less time than CPT 27165 it includes more complex work. CPT 27712 is also more work than CPT 24410, as discussed in the key reference comparison section above. The survey median RVW is recommended because it appropriately places the value of CPT 27712 "relative" to CPT 27165 and CPT 24410.

Public Comments

05-Jul-95

Code: 27712

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Osteotomy, multiple, with realignment on intramedullary rod (Sofield type procedure)

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27712	0	0	0	0	100	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27712	24	22	-4.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27712	87.5	81.8	-2.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27712	group practices	9.1
	orthopedic surgery	90.9

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27712							
	AAOS	090	090	11.30	11.81	1.05	11.81

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27712								
AAOS	11.81	11.81	1.05	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
27712								
AAOS	090	11.30		28	*	119		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27712									
AAOS	*	0.5	*	10	6.5	*	10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
27712									
AAOS	*	10			11.81	or	3		0.046

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27227 Global Period: 090 1995 RVW: 15.39 Recommended RVW: 22.00
Accepted by Workgroup

CPT Descriptor: Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old laborer falls from a scaffold and sustains a displaced acetabular fracture involving the posterior column. He is treated by open reduction and internal fixation through a posterior approach.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to adequacy of radiographs (AP pelvis, Judet views, CT, 3-dimensional reconstruction), evaluation for other injuries (GI, GU, vascular, neurologic), close collaboration with general surgeons, urologists or others planning surgery; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. The interpretation of all imaging studies is vitally important in the surgeon must understand the relationships of each fracture fragment to one another further, the decision concerning the proper surgical approach is dependent on the characteristics of the fracture. Preoperative work also includes preoperative scrubbing; ordering preoperative ultrasound scan for deep venous thrombosis, somatosensory evoked potential baseline studies (SSEP), arterial line, central venous line antibiotics; arranging for intraoperative SSEP monitoring; cell-saver, consulting with anesthesia, fluoroscopy, blood supply; positioning the patient supine, lateral or prone depending on surgical approach, on a special radiolucent operating table extension; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite. After patient positioning, the C-arm should be used prior to draping to ascertain whether adequate views including obliques can be obtained.

Intraoperative work: Fractures of the acetabulum involving one column, or transverse fractures, may be approached through one incision, usually. For anterior fractures, the patient will be positioned supine and an ilioinguinal approach performed. For posterior fractures, the position will be lateral or prone, and a Kocher-Langenbeck incision is the most common. Both are done on a radiolucent operating table extension, with a cell saver, somatosensory evoked potential (SSEP) monitoring, and fluoroscopy. After prepping and draping, the surgeon must attach sterile monitoring electrodes to the posterior tibial nerve and the peroneal nerve and secure them to the skin. These surgical approaches must be extensile to allow adequate mobilization of soft tissues and adequate visualization of vital structures and the fracture. Inadequate exposure will lead to inadequate internal fixation and potential injury to vital structures.

The **ilioinguinal approach** begins with a skin incision starting at the anterior superior iliac spine (ASIS) and extending proximally and laterally along the iliac crest, and distally and medially to the pubis. The lateral window is developed first. The insertion of the abdominal muscles onto the iliac crest is identified and they are removed subperiosteally, leaving a cuff of tissue on the outside of the crest to assist in the closure. The iliacus muscle is elevated from the inside of the pelvis deeply, around to the sacroiliac (SI) joint in back and the pelvic brim medially. This portion of the wound is packed with a swab. The fascia of the external oblique is cleaned carefully from the subcutaneous fat over the abdomen. The spermatic cord is identified and a rubber strip placed around it.

Intraoperative work (continued)

The external ring of the inguinal canal is identified and the fascia of the external oblique is divided carefully from the ASIS to the external ring leaving 3–5 mm of fascia on the inguinal ligament. The lateral femoral cutaneous nerve is identified and protected. The conjoint tendon (fascia of the internal oblique and transversalis) is cleaned and divided 4 mm from the inguinal ligament from the ASIS to the iliopectineal fascia. This fascia represents the lateral border of the vascular compartment. An elevator is carefully advanced subperiosteally along the anterior column of the acetabulum inside the pelvis, underneath the iliopsoas muscle and femoral nerve. This is facilitated by flexion of the hip. A rubber strip is placed around these structures to aid retraction and protection. The iliopectineal fascia is then cleaned carefully on both sides and then divided back along the pelvic brim. The femoral artery and nerve are carefully retracted upward. The surgeon must beware of a connection between the femoral and obturator arteries. If it exists, it must be identified and ligated, lest serious hemorrhage occur. A rubber strip is placed around the vessels. The ipsilateral insertion of the rectus abdominis is then identified and divided, leaving a cuff of tissue to allow repair. Care must be taken to protect the bladder during exposure of the pubis. The exposure is then completed by careful subperiosteal exposure of the anterior column from inside the pelvis, working over the iliac crest, between the nerve and the vessels, or medial to the vessels (the three "windows"). Once the fracture is exposed, the surfaces are cleaned of clot.

The fracture is reduced indirectly by means of manipulation of the bone fragments through the windows. This may be helped by placement of a screw into the proximal femur, allowing an assistant to apply lateral traction, and pull the femoral head out of the pelvis. A variety of specialized reduction clamps are available to perform the reduction. This requires an intimate understanding of the anatomy of this complex joint. Once reduced, the quality of reduction must be evaluated using fluoroscopy in anterior–posterior and oblique projections. This requires an experienced X-ray tech, and is often difficult to interpret. If the reduction is judged to be perfect, plates and screws are applied from inside the pelvis. Flexible reconstruction plates are used, and these must be shaped carefully and exactly to fit the inside of the pelvic brim. Sometimes, additional flexible plates are needed to stabilize the fixation construct. Screws must be directed in such a manner as to hold the fracture without penetrating the joint surface or other dangerous areas, such as the obturator foramen. This requires intimate familiarity with the pelvic anatomy. Once screws are in place, they must be evaluated using fluoroscopy. Some surgeons use a sterile esophageal stethoscope to auscultate the hip for evidence of screw penetration of the joint.

Closure of this approach involves: re-attachment of the rectus abdominis insertion, repair of the conjoint tendon to the inguinal ligament, repair of the external ring taking care to re-establish the correct ring size, repair of the fascia of the external oblique, re-attachment of the abdominal muscles to the iliac crest with suture anchors inserted into bone, and layered closure of the skin and subcutaneous tissues. Hemovac drains are left in the internal iliac fossa, and in the space of Retzius behind the pubis. Portable X-rays are obtained with the patient asleep and the back table sterile.

The Kocher–Langenbeck approach for posterior lesions begins with an incision at the greater trochanter, extending proximally and posteriorly toward the posterior superior iliac spine, and distally along the shaft of the femur. Subcutaneous tissue is divided in line with the incision and the fascia lata is split distally. The gluteus maximus muscle is bluntly split proximally. A portion of the gluteus maximus tendon may be divided. The sciatic nerve is identified distal to the zone of injury behind the quadratus femoris muscle, and followed proximally. The nerve is kept lax by constant vigilance to keep the knee flexed and the hip extended, thus making it less liable to injury. The tendons of the piriformis and of the obturator internus are identified, tagged, divided close to the bone and retracted. A retractor is placed in the bursa of the obturator internus to protect the sciatic nerve. The posterior column of the acetabulum is then exposed subperiosteally, from the ischial tuberosity proximally to the greater sciatic notch and beyond. Care is taken to protect the superior gluteal nerve and artery exiting from the notch. Posterior wall fractures are identified and cleaned of debris, keeping the capsular attachments intact to protect vascularity. Access to the joint is through fracture lines rather than through the capsule.

Intraoperative work (continued)

The head of the femur is retracted from the joint by use of the femoral distractor, a device which provides controlled distraction through screws placed in the ilium and in the proximal femur. The interior of the joint is inspected for fracture fragments or debris. If there is marginal impaction of the acetabular joint surface, it is carefully elevated and molded to the femoral head, and then supported with bone graft taken from a small window made in the greater trochanter. The posterior column fracture is reduced by use of a manipulation screw placed in the ischium, or by use of special reduction clamps. This may require manipulation of bone fragments from inside the pelvis using instruments placed through the greater sciatic notch. It is then stabilized with a flexible reconstruction plate bent and shaped to fit the column. At this point the posterior wall fragments are replaced, and are stabilized with Kirschner wires. Labral tears may be sutured back in place. The reduction is evaluated with fluoroscopy in AP and oblique projections. If it is perfect, another reconstruction plate (with or without supplemental "spring" plates), is contoured carefully to fit over the fragments and buttress them in place. Screws are placed, and may include lag screws through the fragments. Extreme care must be taken to avoid penetration of the joint surface with screws, and this is evaluated with fluoroscopy and/or with a sterile esophageal stethoscope. Sterile drains are placed. Closure of the KL approach consists of: re-attachment of the tendons of the piriformis and obturator internus, repair of the gluteus maximus tendon, closure of the fascia lata, layered closure of the skin. The patient is turned supine and portable X-rays are taken prior to awakening the patient and breaking down the back table.

Postoperative work begins after skin closure in the operating room and includes turning the patient supine take radiographs prior to awakening the patient; and application of dressings, pulsatile stockings, continuous passive motion machine. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including ICU care and monitoring neurologic, vascular, urologic and GI system evaluation, blood counts, cardiopulmonary function; care and removal of drains; adjustments of CPM; supervision of mobilization and ambulation; ordering and reviewing radiographs to assess hardware position and fracture reduction, postoperative CAT scan and ultrasound DVT scans (deep venous thrombosis); and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. This also includes ordering radiation therapy for heterotopic bone prophylaxis, anticoagulation for DVT prophylaxis, and assessing physical therapy progress.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association; American Association of Hip and Knee Surgeons

Survey n:	225	RVW	PRE	INTRA	POST						
Response:	40		total min	total min	Day 1	ICU		Hosp. - Other		Office	
Rate %:	18%				total min	# visits	total min	# visits	total min	# visits	
low	17.00		90								
25th%	18.00		180								
med	22.00	90	180	30	10	1	80	6	60	4	
75th%	25.00		240								
high	32.50		360								

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27227:	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Harvard 27130: Phase 4	61	128	39	0	0	90	9	35	3.5	
Harvard 27132: Phase 4	62	194	40	0	0	105	10	60	4	
Harvard 27222:	47	86	29	0	0	113	11	43	4	

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
18.68	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft
17.29	27254	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
18.68	090	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft
21.44	090	27132	Conversion of previous hip surgery to total hip replacement, with or without autograft or allograft
10.95	090	27222	Closed treatment of acetabulum (hip socket) fracture(s); with manipulation, with or without skeletal traction

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27227 (Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation) involves a treatment of a complex fracture of the body's major weight-bearing joint, requiring careful preoperative planning that integrates information from a variety of imaging studies (eg, X-ray, CT) and extensive preoperative work to review available studies, plan the operation, and supervise and/or personally prepare the patient (positioning) for this emergent operation.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): (continued)

In comparison to CPT 27130 (*Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft*), CPT 27227 is more intense because it involves more complex positioning, more complicated surgical anatomical exposure, and more complexity in terms of fixation, which equates to more preoperative and more intraoperative time. In contrast to total hip replacement patients, the majority of which are medically stable, complex acetabular fractures usually occur in severely injured patients who have greater metabolic, nutritional and hemodynamic derangements. This increase in the severity of associated systemic problems increases the work associated with preoperative, intraoperative, and postoperative management of these fracture patients. Additionally, since many of the acetabular fixations require an extensive intra-pelvic surgical approach or two major incisions, the risk of intraoperative and postoperative complications is far greater than that associated with a total hip replacement.

The surgical approach for a total hip replacement is less extensive than that utilized for acetabular fixation, and is not made through traumatized tissue in which anatomic relationships are often disturbed and the risk of complications is increased. Total hip replacement involves the excision of the proximal femur and the acetabular lining followed by replacement with pre-manufactured standard components which are inserted with a predictable technique. In contrast, fixation of complex acetabular fractures requires exposure, repositioning, and stabilization of multiple displaced bone fragments in order to restore normal hip anatomy. The work involved in this type of bony reconstruction is of greater duration and intensity than the work that is necessary for replacement of the hip joint.

Total hip patients are commonly walking within a few days of the operation, while complex acetabular fractures must be kept non-weight-bearing for three months following the operation. Postoperative and rehabilitative care for the acetabular patient is more complex and requires more physician work than that associated with total hip surgery.

The intensity and complexity of the preoperative and intraoperative work for CPT 27227 is more comparable, if not greater than, CPT 27132 (*Conversion of previous hip surgery to total hip replacement, with or without autograft or allograft*).

In comparison to CPT 27222 (*Closed treatment of acetabulum (hip socket) fracture(s); with manipulation, with or without skeletal traction*), which is a non-operative procedure, the surgical intraoperative work in CPT 27227 involves: an extensive surgical approach through traumatized tissue, past vital neurovascular structures which must be protected throughout the procedure; an anatomic reduction of multiple joint surfaces fragments often requiring specialized instruments and reduction techniques; the application of provisional internal fixation with special clamps and pin fixation; intraoperative radiographs; and definitive internal fixation with custom contoured plates and screws, taking great care to avoid penetration of the joint and injury to neurovascular structures. Also, with the anterior approach, meticulous wound closure is necessary to avoid abdominal wall hernia or inguinal hernia. Postoperatively, CPT 27227 represents intense and prolonged wound care due to the severe nature of the original injury, and assessing the need for and ordering radiation therapy and medications to prevent heterotopic ossification about the operated hip. The intraoperative time for CPT 27227 more than twice that of CPT 27222, and the intensity and complexity is many more times that of CPT 27222.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The recommended RVW, which is the survey median, is higher than CPT 27130 and similar to CPT 27132 and reflects the differences in pre-, intra- and postoperative time, intensity, and complexity, as discussed in the comparison to key references section above.

HCFA incorrectly "judged" CPT 27227 to be less work than CPT 27130 in its original valuation, without the advantage of having a service description (presenting the complexity and intensity of this service) or surveyed service time estimates. Many of the orthopaedic surgeons who served on the Technical Consulting Panel involved with the recommendation to initially value this procedure routinely perform total hip replacements as part of their practice. This is true also of the surgeons from the Orthopaedic Trauma Association and the American Association of Hip and Knee Surgeons who responded to the AMA/RUC 5-year-review survey. These surgeons are most "fit-to-rate" the work value in this complex acetabular fixation relative to total hip replacement, and they have estimated the work and time of CPT 27227 to be higher than for CPT 27130 (i.e., the AMA/RUC survey confirms that CPT 27227 requires more time than CPT 27130.)

In addition, the Orthopaedic RVS Advisory Panel, and the 14,000 Fellows it represents, would like to re-emphasize the concern about inappropriately crosswalking work values from deleted codes to new codes. Deleted codes and their replacement codes do not always represent the same work. Often times, codes are deleted because they have questionable and widely variable misunderstood descriptors, which do not accurately reflect current clinical practice. It should be noted that HCFA incorrectly based its valuation of CPT 27227 on the RVW of a deleted code.

Public Comments

05-Jul-95

Code: 27227

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27227	100	16.7	0	83.3	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27227	.	266	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27227	.	99.2	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27227	orthopedic surgery	97

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27227							
AAOS			090		15.39		

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27227								
AAOS	14.69	15.39	.	.	1.05	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
27227								
AAOS	090	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27227									
AAOS

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27227									
AAOS	15.39	.	.	.	.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27228 Global Period: 090 1995 RVW: 17.90 Recommended RVW: 30.00
Workgroup Recommended New Value: 25.59

CPT Descriptor: Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture, with internal fixation

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old laborer falls from a scaffold and sustains a displaced anterior and posterior column fracture of the acetabulum. He is treated by open reduction and internal fixation through combined anterior and posterior approaches.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to evaluation for intra-abdominal, urologic, or neurologic injury, reviewing and assessing radiographs (AP, Judet views), CT scan (transaxial and 3-dimensional), to decide how and in what order to approach; consulting other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; ordering preoperative ultrasonography to evaluate venous thrombosis, somatosensory evoked potentials (SSEP) to evaluate sciatic nerve; arranging for arterial line, central venous line, and antibiotics; arranging for intraoperative SSEP monitoring, cell-saver, available blood for transfusion, fluoroscopy; positioning the patient first either supine or lateral (to be switched later to the other) on a radiolucent operating table extension; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite. The procedure will begin with one exposure, either from the front or the back, based on which component of the fracture is more displaced. This determination is made by analysis of multiple imaging studies, and requires experience with the procedure to know how the reduction will be performed. After the patient is positioned on a radiolucent table, prepped and draped, and sterile monitoring leads are attached by the surgeon for evoked potential monitoring, the front side is addressed through an ilioinguinal approach.

Intraoperative work: The ilioinguinal approach begins with a skin incision starting at the anterior superior iliac spine (ASIS) and extending proximally and laterally along the iliac crest, and distally and medially to the pubis. The lateral window is developed first. The insertion of the abdominal muscles onto the iliac crest is identified and they are removed subperiosteally leaving a cuff of tissue on the outside of the crest to assist in the closure. The iliacus muscle is elevated from the inside of the pelvis deeply, around to the sacroiliac (SI) joint in back and the pelvic brim medially. This portion of the wound is packed with a swab. The fascia of the external oblique is cleaned carefully from the subcutaneous fat over the abdomen. The spermatic cord is identified and a rubber strip placed around it.

Intraoperative work (continued)

The external ring of the inguinal canal is identified and the fascia of the external oblique is divided carefully from the ASIS to the external ring, leaving 3–5 mm of fascia on the inguinal ligament. The lateral femoral cutaneous nerve is identified and protected. The conjoint tendon (fascia of the internal oblique and transversalis) is cleaned and divided 4 mm from the inguinal ligament from the ASIS to the iliopectineal fascia. This fascia represents the lateral border of the vascular compartment. An elevator is carefully advanced subperiosteally along the anterior column of the acetabulum inside the pelvis, underneath the iliopsoas muscle and femoral nerve. This is facilitated by flexion of the hip. A rubber strip is placed around these structures to aid retraction and protection. The iliopectineal fascia is then cleaned carefully on both sides and then divided back along the pelvic brim. The femoral artery and nerve are carefully retracted upward. The surgeon must beware of a connection between the femoral and obturator arteries. If it exists, it must be identified and ligated, lest serious hemorrhage occur. A rubber strip is placed around the vessels. The ipsilateral insertion of the rectus abdominis is then identified and divided, leaving a cuff of tissue to allow repair. Care must be taken to protect the bladder during exposure of the pubis. The exposure is then completed by careful subperiosteal exposure of the anterior column from inside the pelvis, working over the iliac crest, between the nerve and the vessels, or medial to the vessels (the three "windows"). Once the fracture is exposed, the surfaces are cleaned of clot.

The fracture is reduced indirectly by means of manipulation of the bone fragments through the windows. This may be helped by placement of a screw into the proximal femur, allowing an assistant to apply lateral traction, and pull the femoral head out of the pelvis. A variety of specialized reduction clamps are available to perform the reduction. This requires an intimate understanding of the anatomy of this complex joint. Once reduced, the quality of reduction must be evaluated using fluoroscopy in anterior–posterior and oblique projections. This requires an experienced X-ray technician, and is often difficult to interpret. If the reduction is judged to be perfect, plates and screws are applied from inside the pelvis. Flexible reconstruction plates are used, and these must be shaped carefully and exactly to fit the inside of the pelvic brim. Sometimes, additional flexible plates are needed to stabilize the fixation construct. Screws must be directed in such a manner as to hold the fracture without penetrating the joint surface or other dangerous areas, such as the obturator foramen. This requires intimate familiarity with the pelvic anatomy. Once screws are in place, they must be evaluated using fluoroscopy. If necessary, a sterile esophageal stethoscope is used to auscultate the hip for evidence of screw penetration of the joint. Closure of this approach involves: re-attachment of the rectus abdominis insertion, repair of the conjoint tendon to the inguinal ligament, repair of the external ring taking care to re-establish the correct ring size, repair of the fascia of the external oblique, re-attachment of the abdominal muscles to the iliac crest with suture anchors inserted into bone, and layered closure of the skin and subcutaneous tissues. Hemovac drains are left in the internal iliac fossa, and in the space of Retzius behind the pubis.

After closure of the anterior approach, the drapes are removed, the patient is positioned lateral or prone, re-prepped and draped, and a second surgical approach is performed. New sterile monitoring electrodes must be placed near the peroneal and posterior tibial nerves.

The most common posterior approach is the Kocher–Langenbeck. The Kocher–Langenbeck approach for posterior lesions begins with an incision at the greater trochanter, extending proximally and posteriorly toward the posterior superior iliac spine, and distally along the shaft of the femur. Subcutaneous tissue is divided in line with the incision and the fascia lata is split distally. The gluteus maximus muscle is bluntly split proximally. A portion of the gluteus maximus tendon may be divided. The sciatic nerve is identified distal to the zone of injury behind the quadratus femoris muscle, and followed proximally. The nerve is kept lax by constant vigilance to keep the knee flexed and the hip extended, thus making it less liable to injury. The tendons of the piriformis and of the obturator internus are identified, tagged, divided close to the bone and retracted. A retractor is placed in the bursa of the obturator internus to protect the sciatic nerve. The posterior column of the acetabulum is then exposed subperiosteally, from the ischial tuberosity proximally to the greater sciatic notch and beyond. Care is taken to protect the superior gluteal nerve and artery exiting from the notch.

Intraoperative work (continued)

Posterior wall fractures are identified and cleaned of debris, keeping the capsular attachments intact to protect vascularity. Access to the joint is through fracture lines rather than through the capsule. The head of the femur is retracted from the joint by use of the femoral distractor, a device which provides controlled distraction through screws placed in the ilium and in the proximal femur. The interior of the joint is inspected for fracture fragments or debris. If there is marginal impaction of the acetabular joint surface, it is carefully elevated and molded to the femoral head, and then supported with bone graft taken from a small window made in the greater trochanter. The posterior column fracture is reduced by use of a manipulation screw placed in the ischium, or by use of special reduction clamps. This may require manipulation of bone fragments from inside the pelvis using instruments placed through the greater sciatic notch. It is then stabilized with a flexible reconstruction plate bent and shaped to fit the column. At this point the posterior wall fragments are replaced, and are stabilized with Kirschner wires. Labral tears may be sutured back in place. The reduction is evaluated with fluoroscopy in AP and oblique projections. If it is perfect, another reconstruction plate (with or without supplemental "spring" plates), is contoured carefully to fit over the fragments and buttress them in place. Screws are placed, and may include lag screws through the fragments. Extreme care must be taken to avoid penetration of the joint surface with screws, and this is evaluated with fluoroscopy and/or with a sterile esophageal stethoscope. Sterile drains are placed. Closure of the KL approach consists of: re-attachment of the tendons of the piriformis and obturator internus, repair of the gluteus maximus tendon, closure of the fascia lata, and layered closure of the skin. The patient is turned supine and portable X-rays are taken prior to awakening the patient and breaking down the back table.

The intra operative work of this procedure is especially difficult since both anterior and posterior columns of the acetabulum are fractured and essentially are "floating free". Anchoring and stabilizing the fracture fragments is an especially difficult technical activity.

Postoperative work begins after skin closure in the operating room and includes application of dressings and continuous passive motion machine. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including ICU care and evaluating neurologic and vascular status, blood counts (hemoglobin), cardiopulmonary status; care and removal of suction drain, central line, and arterial line; adjustments of continuous passive motion device; supervision of mobilization and ambulation; coordination of care for other injuries; ordering and reviewing postoperative radiographs of the pelvis (AP and Judets), CAT scan, ultrasound duplex scans to assess deep venous thrombosis; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. This would also include ordering radiation therapy for heterotopic bone prophylaxis and anticoagulation for blood clot prophylaxis; supervising physical therapy and rehabilitation

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association; American Association of Hip and Knee Surgeons

Survey n: 225
 Response: 40
 Rate %: 18%

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
					total min	# visits	total min	# visits	total min	# visits
low	20.00		120							
25th%	25.50		240							
med	30.00	80	300	30	25	1	90	6	90	4
75th%	35.00		360							
high	54.00		540							

HARVARD / RUC DATA for surveyed service and key reference service(s):

Harvard 27228:	n/a									
Harvard 27227:	n/a									
Harvard 20816:	87	282	38	0	0	9	1	31	1	
RUC 20816: (1994)	60	360	45	0	0	105	7	65	5	
Harvard 27130: Phase 4	61	128	39	0	0	90	9	35	3.5	
Harvard 27132: Phase 4	62	194	40	0	0	105	10	60	4	
Harvard 35082:	84	226	52	31	2	154	12	54	4	
RUC 473xx: (1995)**	40	180	**	**	5	**	15	55	4	

**The time estimates for this new code were presented at the April 1995 AMA/RVS Update Committee meeting. Total median postoperative time was estimated at 180 minutes.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
29.67	20816	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon); complete amputation
18.68	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
29.67	090	20816	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon); complete amputation
18.68	090	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft
21.44	090	27132	Conversion of previous hip surgery to total hip replacement, with or without autograft or allograft
28.82	090	35082	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta
(15.39/22.00) ^A	090	27227	Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation
(28.00) ^B	090	(473xx) ^B	Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver

^A This procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 15.39 to 22.00, is being presented.

^B This new code was presented at the April 1995 AMA/RVS Update Committee meeting. The RVW shown is the recommended value. An RVW has not been published yet in the Federal Register.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27228 (*Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture, with internal fixation*) has been acknowledged by orthopaedic surgeons to be the most difficult management problem in the universe of orthopaedic trauma care.

It can be broadly stated that this procedure ranks par with CPT 473xx (*Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver*) or CPT 35082 (*Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta*). In general terms, all three procedures require extensive, exacting exposure; have a high operative risk to neurovascular structures; require an extraordinary amount of skill and experience to visualize and correct; and have a high risk of postoperative wound complications. In terms of **total work**, CPT 27228 makes up in time and complexity, what it may lack in life-threatening intensity as compared to CPT 473xx and CPT 35082.

Similarly, CPT 27228 ranks par with CPT 20816 (*Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon); complete amputation*). Both procedures require an extraordinary amount of skill and experience to visualize and correct; and both have a high risk of postoperative wound complications. Although CPT 20816 does not require extensive exposure because the finger has been completely amputated, significant time is required to microsurgically debride, dissect, and repair the severed tendons and neurovascular structures.

In comparison to CPT 27130 (*Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft*), CPT 27228 is more intense because it involves more complex positioning, more complicated surgical anatomical exposure, and more complexity in terms of fixation, which equates to more preoperative and more intraoperative time. In contrast to total hip replacement patients, the majority of which are medically stable, complex acetabular fractures usually occur in severely injured patients who have greater metabolic, nutritional and hemodynamic derangements. This increase in the severity of associated systemic problems increases the work associated with preoperative, intraoperative, and postoperative management of these fracture patients. Additionally, since many of the acetabular fixations require an extensive intra-pelvic surgical approach or two major incisions, the risk of intraoperative and postoperative complications is far greater than that associated with a total hip replacement. The surgical approach for a total hip replacement is less extensive than that utilized for acetabular fixation, and is not made through traumatized tissue in which anatomic relationships are often disturbed and the risk of complications is increased. Total hip replacement involves the excision of the proximal femur and the acetabular lining followed by replacement with pre-manufactured standard components which are inserted with a predictable technique. In contrast, fixation of complex acetabular fractures requires exposure, repositioning, and stabilization of multiple displaced bone fragments in order to restore normal hip anatomy. The work involved in this type of bony reconstruction is of greater duration and intensity than the work that is necessary for replacement of the hip joint. Total hip patients are commonly walking within a few days of the operation, while complex acetabular fractures must be kept non-weight-bearing for three months following the operation. Postoperative and rehabilitative care for the acetabular patient is more complex and requires more physician work than that associated with total hip surgery.

The intensity and complexity of the preoperative and intraoperative work for CPT 27228 is greater than, CPT 27132 (*Conversion of previous hip surgery to total hip replacement, with or without autograft or allograft*).

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The recommended RVW, which is the survey median, is similar to the published RVW for CPT codes 35083 and 20816, and the RUC-accepted RVW for CPT 473xx, and reflects the similarities in time and work, as discussed in the comparison to key references section above.

HCFA incorrectly "judged" CPT 27228 to be less work than CPT 27130 in its original valuation, without the advantage of having a service description (presenting the complexity and intensity of this service) or surveyed service time estimates. Many of the orthopaedic surgeons who served on the Technical Consulting Panel involved with the recommendation to initially value this procedure routinely perform total hip replacements as part of their practice. This is true also of the surgeons from the Orthopaedic Trauma Association and the American Association of Hip and Knee Surgeons who responded to the AMA/RUC 5-year-review survey. These surgeons are most "fit-to-rate" the work value in complex acetabular fixation relative to total hip replacement, and they have estimated the work and time of CPT 27228 to be higher than for CPT 27130 (i.e., the AMA/RUC survey confirms that CPT 27228 requires more time than CPT 27130 or CPT 27132.)

In addition, the Orthopaedic RVS Advisory Panel, and the 14,000 Fellows it represents, would like to re-emphasize the concern about inappropriately crosswalking work values from deleted codes to new codes. Deleted codes and their replacement codes do not always represent the same work. Often times, codes are deleted because they have questionable and widely variable misunderstood descriptors, which do not accurately reflect current clinical practice. It should be noted that HCFA incorrectly based its valuation of CPT 27228 on the RVW of a deleted code.

Public Comments

30-Jun-95

Code: 27228 **1995 RVUs:** **Recommended RVUs:** **Ratio:**

Long Descriptor: Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture, with internal fixation

Reference Set (y/n): **Global Period:** 090 **Frequency:** **Impact:**

Source: **Year:** **Public Comment Letter:** AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AAP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27228	33.3	11.1	0	11.1	11.1	0	11.1	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27228		189	

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27228		92.6	

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27228	ophthalmology	5.3
	orthopedic surgery	94.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
27228	715	2.8	OSTEOARTHRISIS AND ALLIED DISORD
	733	2.8	OTHER DISORDERS OF BONE AND CART
	805	2.8	FRACTURE OF VERTEBRAL COLUMN WI
	808	22.2	FRACTURE OF PELVIS

Public Comments

30-Jun-95

835	2.8	DISLOCATION OF HIP
E885	2.8	FALL ON SAME LEVEL FROM SLIPPING, T

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27228							
AAOS			090		17.90		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27228								
AAOS	17.08	17.90			1.05	1.00	49.53	25

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
27228								
AAOS	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27228									
AAOS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27228									
AAOS				49.53	17.90				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27724 Global Period: 090 1995 RVW: 12.11 Recommended RVW: 15.38
Workgroup Recommended New Value: 13.88

CPT Descriptor: Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old football player sustained a fracture of his mid-shaft tibia during a game one year ago. The fracture healed, with a 30 degree varus angulation. After bone healing, the malunion is corrected by an osteotomy, plating, with an autograft from the iliac crest applied to the nonunion site.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to creation of preoperative planning sketches traced from X-rays of the malunited and normal tibia, which shows the planned level of bone cuts, placement of implants, expected correction and has a written surgical tactic (if a nonunion, may need bone scans or indium scans to R/O infection); consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; ordering preoperative antibiotics; arranging for intraoperative portable radiographs, possible neurologic function monitoring, blood products (standby--type and cross); positioning and tourniquet placement (for correction of a tibial malunion, the patient is positioned supine on a radiolucent table, with a bump under the hip and a pneumatic tourniquet around the upper leg, the preoperative plan drawings made by the surgeon must be brought into the room and placed up on the viewbox, and the iliac crest should be prepped to allow bone graft harvest); supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: After inflation of the tourniquet, a straight incision is made anteriorly through the skin just lateral to the crest of the tibia and centered over the deformity. Full thickness skin and subcutaneous tissue flaps must be carefully developed, with very gentle handling of the tenuous soft tissue envelope in this region. Exposure of the tibia may be done subperiosteally or extraperiosteally, but it needs to be circumferential at the level of the osteotomy cut in order to allow protection of the neurovascular structures posterior to the bone. Excessive stripping should be avoided, yet exposure must be adequate to allow a safe osteotomy, and this requires experience and judgment. Once the bone is exposed, the osteotomy is performed using an oscillating saw, at the level and orientation as indicated on the preoperative plan. Neurovascular structures are protected with retractors. Prior to correction of the deformity, the fibula may need to be osteotomized, and this may usually be done with an osteotome through a small incision (but not percutaneously). In the case of an oblique osteotomy, the deformity is corrected by rotating the distal fragment around the axis of the osteotomy using a femoral distractor on the appropriate side. For correction of a varus deformity, the distractor is placed medially. Three dimensional alignment and length is corrected, a clamp is placed across the osteotomy, and a lag screw used to compress the cut surfaces.

Intraoperative work continued:

Usually intraoperative films showing the ankle and knee are obtained to verify alignment. If satisfactory, the bone contours may be fine-tuned, a neutralization plate shaped to fit the anteromedial surface of the tibia, and attached with cortical screws. Bone graft, either simultaneously or previously harvested from the iliac crest or distal femur, is placed around the osteotomy site. The wound is irrigated, Hemovac drains placed, and the soft tissues carefully closed in layers. If an extensive valgus deformity or excessive shortening exists, correction is often done using somatosensory evoked potential monitoring to reduce the risk of stretch injury to the nerves.

Postoperative work begins after skin closure in the operating room and includes application of dressing and splints or a cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status and function, wound status and healing (tenuous soft tissues); care and removal of suction drains; adjustments of removable splint; supervision of rehabilitation and ambulation, and use of bone stimulator for nonunion; ordering and reviewing radiographs to assess alignment, position, healing; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures and cast changes; evaluation of periodic imaging until bone healing has occurred and laboratory reports, if needed antibiotic and pain medication adjustments. The surgeon orders physical therapy and directs the ambulation recovery program dependant on the rate of bone healing.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association

Survey n: Response: Rate %:	179 40 22%	RVW	PRE	INTRA	POST						
			total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
						total min	# visits	total min	# visits	total min	# visits
low	13.00		90								
25th%	14.20		130								
med	15.38	60	160	30	0	0	60	4	75	5	
75th%	17.73		180								
high	25.00		300								

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27724:	61	139	28	0	0	55	5.5	50	5
Harvard 27758:	62	126	27	0	0	71	6	56	5
Harvard 20902:	33	63	23	0	0	35	4	24	3

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
10.51	27758	Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage
16.20	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
10.51	090	27758	Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage
6.74	090	20902	Bone graft, any donor area; major or large

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

In comparison to CPT 27758 (*Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage*), CPT 27724 (*Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)*) involves a radically more extensive exposure, with debridement of infected tissue often necessary. In the case of malaligned nonunion and malunions, there is extensive bone excision, osteotomy, and realignment. If internal fixation is necessary, it would be comparable to insertion of plate/screws or nail in CPT 27758.

The bone graft necessary for CPT 27724 is extensively applied to the poster and anterior fibula. Dissection goes in the plane between the calf muscles and interosseous member and the bone graft must be distributed across the surface of the tibia and space between tibia and fibula.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This increased RVW is more than the RVW for CPT 27758 (10.51) plus 50% of the RVW for CPT 20902 (6.74), and accurately reflects the work (and time) components that comprise this service.

$$[10.51 + 3.37 = 13.88]$$

Public Comments

05-Jul-95

Code: 27724

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27724	23.1	0	15.4	46.2	53.8	0	0	8.3

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
27724	539	496	-4

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27724	90.4	92.3	1

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
27724	orthopedic surgery	97.6

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27724	AAOS		090	090	12.03	12.11	1.01	12.11

Harvard Data:

Public Comments

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27724								
AAOS	12.11	12.11	1.01	1.00	1.00	1.00	.	

Harvard Data:

Comm	Peck95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notatt	Imppt
27724								
AAOS	090	12.03		39		139		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27724									
AAOS		0.5	*	10	5.5		10	0.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27724									
AAOS		10			12.11	or	3		0.043

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27827 Global Period: 090 1995 RVW: 9.90 Recommended RVW: 15.35
Workgroup Recommended New Value: 12.95

CPT Descriptor: Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 24-year-old male with a displaced articular (pilon) fracture of the distal tibia undergoes open reduction and internal fixation of the distal tibia and its articular surface.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies with special attention to evaluation of plain X-rays of injured and uninjured side for pre-operative planning sketches to show implant placement and preparing a written surgical tactic, obtaining CT scan with 3-dimensional reconstructions, and neurovascular exams; assessment of soft tissue swelling and status to confirm appropriate time for operation; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; ordering preoperative antibiotics; arranging for intraoperative fluoroscopy and positioning of the patient on a radiolucent table extension; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite. These fractures tend to produce fragments displaced in the anterior, posterior, lateral and transverse planes. The weight bearing surface of the distal tibia is severely distorted leaving little or no intact surface with which to articulate with the tibia. This displaced orientation is difficult to assess without the use of pre-operative CT scanning.

Intraoperative work: After the patient is positioned supine on a radiolucent table, with a bump under the hip, preoperative planning sketches and tactic are set up on the viewbox, and the iliac crest is prepped and draped for possible bone grafting, a femoral distractor or external fixator is applied to the medial side with pins placed proximally perpendicular to the shaft and distally through the calcaneus, through separate stab wounds. This allows partial correction of the deformity through indirect reduction. An anteromedial incision is made, after inflation of the tourniquet, medial and parallel to the anterior tibialis tendon, extending across the joint and then curving toward the medial malleolus. Delicate handling of this skin is imperative. Hemostasis is accomplished with the electrocautery. The tendon sheath of the anterior tibialis is reflected laterally and the fascia along its medial edge is incised, taking care not to enter the sheath. The dorsalis pedis artery and superficial peroneal nerve is reflected laterally with the tendon sheath. The joint capsule is opened and some of the anterior fat pad is resected to allow good exposure of the joint surface. Extra-periosteal exposure of the metaphysis and shaft is performed, taking care to be very gentle with the tenuous soft tissues, and maintain full thickness skin and subcutaneous tissue flaps. Fracture lines should be utilized for access to the joint and soft tissue attachments to bone fragment should be scrupulously preserved. The joint surface should be reduced and stabilized provisionally with Kirschner wires based upon the preoperative plan and surgical tactic. Generally, one begins with the anteromedial corner where it is attached to the fibula by strong syndesmotic ligaments, and rebuild the joint medially. Impacted metaphyseal fragment may need to be gently disimpacted, repositioned using the talar dome as a mold, and bone grafted using cancellous bone taken from the distal femur or iliac crest. Metaphyseal defects are grafted. Reduction is evaluated by visualizing the joint surface (aided by the distractor) and by use of the C-arm fluoroscope. The K-wires are then replaced by lag screws.

Intraoperative work (continued)

The reconstructed joint surface is then reconnected to the shaft using a plate. Generally a low-profile plate such as a clover-leaf plate would be used. The plate is placed anteriorly or medially. In some torsional-type fractures, a dynamic compression plate may be appropriate, but should be recessed into the metaphysis using an groove made with an osteotome. Shaft fragments and fracture lines should be stabilized using lag screws through the plate if possible. (At two hours of tourniquet time, the tourniquet should be deflated.) The wound is irrigated, a suction drain is placed, and the fascia is repaired to the anterior tibialis sheath. The joint capsule is closed. The skin is closed in layers, taking care to prevent any tension on the skin closure. If the wound can't be closed without tension, it should be left open and closed later, after the swelling has subsided.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and splint. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring of swelling and neurovascular status; care and removal of drain; adjustments of splint; supervision of mobilization of patient and joint; ordering and reviewing radiographs to assess alignment; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and planned physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; assessment of physiotherapy progress; evaluating weightbearing status; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. Prolonged non-weight bearing status (up to 3 months) must be maintained by the surgeon until x-rays demonstrate healing.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association; American Orthopaedic Foot and Ankle Society

Survey n: Response: Rate %:	223 60 27%	RVW	PRE	INTRA	POST						
			total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
						total min	# visits	total min	# visits	total min	# visits
low	10.00		45								
25th%	13.60		120								
med	15.35	60	150	30	0	0	45	4	75	5	
75th%	17.00		180								
high	30.00		280								

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27827:	n/a									
Harvard 27514:	49	135	22	0	0	66	6	54	4	
Harvard 27766:	43	77	21	0	0	41	4	45	4	
Harvard 27822:	46	106	21	0	0	47	4	48	4	
Harvard 27823:	47	117	21	0	0	51	4	50	4	

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
10.90	27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip
15.95	27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
15.95	090	27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation
[7.61	090	27766	Open treatment of medial malleolus fracture, with or without internal or external fixation]*
[8.39	090	27822	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip]*
10.90	090	27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip

*CPT 27766 and CPT 27822 are presented here as a comparable services offered by HCFA in 1992. The discussion below and in the Rational section will discuss the appropriateness of these choices.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

In 1992, CPT 27766 (*Open treatment of medial malleolus fracture, with or without internal or external fixation*) was cited by HCFA as a comparable service to CPT 27827 (*Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only*) (see Rationale). CPT 27766 is inappropriate to cite as comparable because it involves an isolated injury of a non-weight bearing portion of the ankle joint.

CPT codes 27822 (*Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip*) and 27823 (*Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip*) are more appropriate as reference services because they involve a greater portion of the ankle joint and reflect an injury that is more clinically similar to the injury involved in CPT 27827.

Surgical treatment is more difficult in CPT 27827 than it is in reference services 27822 and 27823 because it requires a more complex surgical approach, an exacting reduction involving multiple small bone fragments of the weight bearing surface of the distal tibia, and extensive fixation using multiple screws and plates. Pre- and postoperative care is more difficult due to the magnitude of bony and soft tissue injury and the increased danger of soft tissue infection, osteomyelitis, and post-traumatic arthritis and joint stiffness.

CPT 27827 (*Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only*) is similar with respect to the estimated service time of CPT 27514 (*Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation*), however, because it involves a more demanding intra-articular fixation and more extensive exposure, CPT 27827 is a more intense procedure. Additionally, with CPT 27827, there are frequently problems with overlying skin that require careful soft tissue handling.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It should be noted that a recommendation to increase the RVW for CPT 27827 was made in 1992. The following selected text presents HCFA's response to this request:

"Treatment of fractures of weight-bearing articular surface of the tibia (CPT code 27827). The RUC recommended work RVUs of 13.65 for code 27827, noting that the work was 34 percent greater than that for code 27822, the treatment of an open trimalleolar ankle fracture. We disagree with this recommendation because we do not agree with the reference service. We set the work RVUs at 8.01, which is comparable to the work RVUs for the open treatment of a medial malleolar fracture (code 27766) and slightly less than those for the open treatment of a trimalleolar fracture (code 27822), which we view as a service of greater intensity. " [Federal Register, Vol. 57, No. 228, November 25, 1992]

The decision to use CPT 27766 as a comparable reference service and CPT 27822 as a service that involves more work was inappropriate (see discussion above in reference service comparison section). CPT code 27822 can be used as a reference service, however it is less work than 27827, not more.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the initial valuation of CPT 27827 did not correctly estimate the work involved in providing this service. The current survey and the judgment of the Advisory Panel equate this service to CPT 27514, and, as such, the survey median RVW, which approximates the RVW for 27514, is recommended to set an accurate value for CPT 27827.

Public Comments

05-Jul-95

Code: 27827

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

--

Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27827	25	0	0	50	25	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27827	.	208	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27827	.	88.5	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27827	group practices	3.8
	orthopedic surgery	95.2

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27827							
	AAOS		090	.	9.90	.	.

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27827								
AAOS	7.61	9.90	.	.	1.30	1.00	.	.

Harvard Data:

Comm	Pack95	Hrvtotwk	Notatw	Pret	Svdpre	Itme	Notett	Imppt
27827								
AAOS	090	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27827									
AAOS

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27827									
AAOS	9.90	.	.	.	.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27828 Global Period: 090 1995 RVW: 12.33 Recommended RVW: 18.00
Workgroup Recommended New Value: 15.12

CPT Descriptor: Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 27-year-old female with a displaced articular (pilon) fracture of the distal tibia and fibula undergoes an open reduction of the distal tibia, its articular surface, and the fibula.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies with special attention to evaluation of plain X-rays of injured and uninjured side for pre-operative planning sketches to show implant placement and preparing a written surgical tactic, obtaining CT scan with 3-dimensional reconstructions, and neurovascular exams; assessment of soft tissue swelling and status to confirm appropriate time for operation; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; ordering preoperative antibiotics; arranging for intraoperative fluoroscopy and positioning of the patient on a radiolucent table extension; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite. These fractures tend to produce fragments displaced in the anterior, posterior, lateral and transverse planes. The weight bearing surface of the distal tibia is severely distorted leaving little or no intact surface with which to articulate with the tibia. This displaced orientation is difficult to assess without the use of pre-operative CT scanning.

Intraoperative work: After the patient is positioned supine on a radiolucent table, with a bump under the hip, preoperative planning sketches and tactic are set up on the viewbox, and the iliac crest is prepped and draped for possible bone grafting, a femoral distractor or external fixator is applied to the medial side with pins placed proximally perpendicular to the shaft and distally through the calcaneus, through separate stab wounds. This allows partial correction of the deformity through indirect reduction. The fibula fracture is addressed first. An incision is made over the posterior edge of the fibular shaft, allowing as much distance as feasible between the fibular incision and the planned tibial incision, at least 7-8 cm. The fibula should be exposed subperiosteally, taking care to protect the peroneal tendons posteriorly. Correction of fibular length and rotation is essential to restoring the overall alignment; anatomic reduction and fixation using lag screws and a neutralization plate is performed. Usually a thin 1/3 tubular plate is used. In cases of comminution, indirect reduction techniques may be employed. This wound is closed in layers. The fixation of the fibula should be performed prior to inflation of the tourniquet, to save tourniquet time for tibial fixation.

Attention is next directed to the fibula fracture. An anteromedial incision is made, after inflation of the tourniquet, medial and parallel to the anterior tibialis tendon, extending across the joint and then curving toward the medial malleolus. Delicate handling of this skin is imperative. Hemostasis is accomplished with the electrocautery. The tendon sheath of the anterior tibialis is reflected laterally and the fascia along its medial edge is incised, taking care not to enter the sheath. The dorsalis pedis artery and superficial peroneal nerve is reflected laterally with the tendon sheath. The joint capsule is opened and some of the anterior fat pad is resected to allow good exposure of the joint surface.

Intraoperative work (continued):

Extra-periosteal exposure of the metaphysis and shaft is performed, taking care to be very gentle with the tenuous soft tissues, and maintaining full thickness skin and subcutaneous tissue flaps. Fracture lines should be utilized for access to the joint and soft tissue attachments to bone fragment should be scrupulously preserved. The joint surface should be reduced and stabilized provisionally with Kirschner wires based upon the preoperative plan and surgical tactic.

Generally, one begins with the anteromedial corner where it is attached to the fibula by strong syndesmotic ligaments, and rebuilds the joint medially. Impacted metaphyseal fragment may need to be gently disimpacted, repositioned using the talar dome as a mold, and bone grafted using cancellous bone taken from the distal femur or iliac crest.

Metaphyseal defects are grafted. Reduction is evaluated by visualizing the joint surface (aided by the distractor) and by use of the C-arm fluoroscope. The K-wires are then replaced by lag screws. The reconstructed joint surface is then reconnected to the shaft using a plate. Generally a low-profile plate such as a clover-leaf plate would be used. The plate is placed anteriorly or medially. In some torsional-type fractures, a dynamic compression plate may be appropriate, but should be recessed into the metaphysis using a groove made with an osteotome. Shaft fragments and fracture lines should be stabilized using lag screws through the plate if possible. The wound is irrigated, a suction drain is left, and the fascia is repaired to the anterior tibialis sheath. The joint capsule is closed. The skin is closed in layers, taking care to prevent any tension on the skin closure. If the wound can't be closed without tension, it should be left open and closed later.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and splint. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring of swelling and neurovascular status; care and removal of drain; adjustments of splint; supervision of mobilization of patient and joint; ordering and reviewing radiographs to assess alignment; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and planned physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; assessment of physiotherapy progress; evaluating weightbearing status; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. Prolonged non-weight bearing status (up to 3 months) must be maintained by the surgeon until x-rays demonstrate healing.

SURVEY DATA:

Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association; American Orthopaedic Foot and Ankle Society

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
					total min	# visits	total min	# visits	total min	# visits
low	12.50		70							
25th%	15.70		150							
med	18.00	70	180	30	0	0	55	4	80	6
75th%	20.00		225							
high	30.00		300							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27828:	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Harvard 27822:	46	106	21	0	0	47	4	48	4
Harvard 27823:	47	117	21	0	0	51	4	50	4
Harvard 27814:	44	87	37	0	0	48	4	45	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
10.90	27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip
15.95	27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

8.39	090	27822	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip
[9.87	090	27814	Open treatment of bimalleolar ankle fracture, with or without internal or external fixation]*
10.90	090	27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip

*CPT 27814 is presented here as a comparable service offered by HCFA in 1992. The discussion below and in the Rationale section will discuss the appropriateness of these choices.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27814 (*Open treatment of bimalleolar ankle fracture, with or without internal or external fixation*) was cited by HCFA as a comparable service to CPT 27828 (*Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula*) (see Rationale). CPT 27828 is inappropriate to cite as comparable because it involves an injury to two areas of a non-weight bearing portions of the ankle joint.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): (continued)

CPT codes 27822 (*Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip*) and 27823 (*Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip*) are more appropriate as reference services because they involve a greater portion of the ankle joint and reflect an injury that is more clinically similar to the injury involved in CPT 27828.

Surgical treatment is more difficult in CPT 27828 than it is in reference services 27822 and 27823 because it requires a more complex surgical approach, an exacting reduction involving multiple small bone fragments of the weight bearing surface of the distal tibia and fibula, and extensive fixation using multiple screws and plates. Pre- and postoperative care is more difficult due to the magnitude of bony and soft tissue injury and the increased danger of soft tissue infection, osteomyelitis, and post-traumatic arthritis and joint stiffness.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It should be noted that a recommendation to increase the RVW for CPT 27828 was made in 1992. The following selected text presents HCFA's response to this request:

Treatment of fracture of weight-bearing articular surface of the tibia (CPT code 27825, 27828). The RUC recommended work RVUs of 15.93 for code 27828 based on a recommendation from AAOS that the work represented 1.57 times the work of code 27822. We do not agree with this comparison and have established work RVUs of 10.40, which are the work RVUs for the open treatment of a bimalleolar ankle fracture (code 27814), which we believe is a better reference service." [Federal Register, Vol. 57, No. 228, November 25, 1992]

The decision to use CPT 27814 as a comparable reference service was inappropriate (see discussion above in reference service comparison section). CPT codes 27822 and 27823 are better reference services

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the initial valuation of CPT 27828 did not correctly estimate the work involved in providing this service. The current AMA/RUC survey and the judgment of the Advisory Panel equate this service to 1.5 times the work for CPT codes 27822 and 27823, and, as such, the survey median RVW, is recommended .

Public Comments

05-Jul-95

Code: 27828

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27828	50	8.3	8.3	75	8.3	0	0	9.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27828		395	

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27828		93.4	

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27828	general/family practice	3
	group practices	2
	orthopedic surgery	94.9

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27828							
	AAOS		090		12.33		

Public Comments

05-Jul-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27828								
AAOS	9.87	12.33	.	.	1.25	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
27828								
AAOS	090	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27828									
AAOS

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27828									
AAOS	12.33	.	.	.	.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 28415 Global Period: 090 1995 RVW: 13.28 Recommended RVW: 15.00
Accepted by Workgroup

CPT Descriptor: Open treatment of calcaneal fracture, with or without internal or external fixation;

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male sustains a comminuted calcaneal fracture after falling from a height. To reconstruct the fracture and joint surface, an open reduction of the intra-articular fracture of the calcaneus is performed using plates and screws.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to radiographs of the operative site, examination of lower extremity ipsi and contralateral; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes preoperative scrubbing; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: For open treatment of a calcaneal fracture, a large L-shaped incision is made on the lateral aspect of the foot and ankle starting just anterior to the Achilles tendon from the musculotendinous junction down along the border of the heel at the junction of the medial and plantar skin, going out to the base of the 5th metatarsal. This incision is then low enough to include and not embarrass the sural nerve. Subperiosteal dissection is then carried out over the lateral border of the heel proximally exposing the Achilles tendon, the Achilles tendon insertion, the lateral border of the calcaneus, the peroneal tendons and the base of the 5th metatarsal. Soft tissues attached to the lateral border of the calcaneus are subperiosteally dissected proximally including the peroneal tendons as they go under the fibula. This whole sheet of tissue including the tendons, neural and vascular structures, is refracted to proximal to the tip of the fibula and proximal to the subtalar joint and held in place with self-retaining wires that are placed within the fibula and within the body of the talus and bent backward to hold this large soft tissue flap without excess traction or embarrassment. In a solid portion of the calcaneal tuberosity, a pin is inserted as well as in the distal third of the tibia, and a bone distractor is applied to these two pins to help regain length of the crushed calcaneus. The fracture hematoma and scattered pieces of soft tissue are removed to expose the subtalar joint, body of the calcaneus and the sinus tarsi. The multiple depressions seen within the articular surface of the posterior facet and the malrotation of the fracture fragments are carefully repositioned and held in place with guide wires. The blown out lateral wall of the calcaneus is opened and further elevation of fragments is carried out with pressure from underneath the fragments using an osteotome.

Intraoperative work (continued):

A medial counter incision is then made over the sustentaculum tali on the medial side of the foot. Blunt and sharp dissection assure that no neurovascular structures are in the way, and a guide wire is then passed from the sustentaculum tali medially through the calcaneus emerging through the lateral wound. With the fracture fragments out to length and proper height, the multiple wires that have been used to position them are replaced with cannulated screws driven over the wires and confirmed by x-ray control. A calcaneal fracture plate, Y-type, is then positioned and bent to the appropriate diameter and configuration of the lateral wall with one of the holes including the guide wire going into the sustentaculum tali. With the fracture plate intact, multiple screws are then placed in the body of the calcaneus through this plate acting as a buttress plate laterally to hold the construct intact. Prior to putting on the plate, the distal calcaneocuboid articular surface is also inspected to make sure that it has been anatomically reduced, and additional screw fixation is carried out to maintain the integrity of that articular surface. The guide wire going through the sustentaculum tali is also replaced with a cannulated screw to get good fixation into that solid area of bone. The pins for the bone distractor are then removed. Copious irrigation is carried out. Drains are placed in the depth of the wound. The wound is closed in layers.

Postoperative work begins after skin closure in the operating room and includes application of cast and splint. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; care and removal of drains; cast and splint adjustments; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and planned physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including cast/splint adjustments and removal; removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; assessing physiotherapy progress; and antibiotic and pain medication adjustments. Prolonged non-weight bearing status (up to 3 or 4 months) must be maintained by the surgeon until x-rays demonstrate healing.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association; American Orthopaedic Foot and Ankle Society

Survey n:	223	PRE	INTRA	POST							
Response:	53			RVW	total min	total min	Day 1 total min	ICU		Hosp. - Other		Office
Rate %:	24%	total min	# visits					total min	# visits	total min	# visits
low	11.50		90								
25th%	13.00		120								
med	15.00	30	150	30	0	0	45	3	80	5	
75th%	17.50		180								
high	25.00		300								

HARVARD DATA for surveyed service and key reference service(s):

Harvard 28415:	40	103	27	0	0	35	3.5	40	4
Harvard 27827:	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Harvard 27514:	49	135	22	0	0	66	6	54	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
10.90	27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip
15.95	27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
15.98	090	27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation
(9.90/15.35)*	090	27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only

*Note: this procedure was surveyed as part of the 5-year review. A recommendation to increase the RVW from 9.90 to 15.35, is being presented.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 28415 (*Open treatment of calcaneal fracture, with or without internal or external fixation*;) is a more complex exposure (often requiring a second incision) of an intra-articular fracture with increased comminution and more difficult fixation than CPT 27514 (*Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation*)

CPT 27827 (*Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only*) represents similar work.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation, and the AMA/RUC survey confirms, that the Harvard study estimate of intraoperative time for CPT 28615 does not accurately reflect the current patient in need of this service. Advances in imaging technology have allowed for a better ability to characterize different patterns of this fracture. There has thus been a movement to address more complex patients who require more time and work. This is supported by the response to survey question 4b which indicated that patients requiring this service are now "more complex (more work)."

Public Comments

05-Jul-95

Code: 28415

1995 RVUs: 13.28

Recommended RVUs:

Ratio:

Long Descriptor: Open treatment of calcaneal fracture, with or without internal or external fixation;

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: APMA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
28415	23.1	0	0	53.8	30.8	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28415	435	456	2.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28415	77.2	80.7	1.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28415	group practices	3.1
	orthopedic surgery	87.7
	podiatry	7

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28415							
AAOS		090	090	8.28	13.28	1.60	9.39

Harvard Data:

Public Comments05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28415								
AAOS	13.28	13.28	1.13	1.41	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
28415								
AAOS	090	8.28		23	*	103		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
28415									
AAOS	*	1.0	*	10	3.5	*	10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
28415									
AAOS	*	10		.	13.28	or	3		0.038

Public Comments

05-Jul-95

Code: 28615

1995 RVUs: 5.12

Recommended RVUs:

Ratio:

Long Descriptor: Open treatment of tarsometatarsal joint dislocation, with or without internal or external fixation

Reference Set (y/n): Global Period: 090 Frequency: Impact:

Source: Year: Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment: APMA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
28615	33.3	0	0	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28615	171	136	-10.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28615	72.5	72.1	-0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28615	orthopedic surgery	85.3
	podiatry	13.2

Harvard Data:

Comm	Modif	Packhrv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28615							
	AAOS	090	090	6.99	5.12	0.73	5.12

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28615								
AAOS	5.12	5.12	0.73	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
28615								
AAOS	090	6.99		22	*	83		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
28615									
AAOS	*	1.0	*	10	2.0	*	10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
28615									
AAOS	*	10			5.12	or	3		0.042

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 28615 **Global Period:** 090 **1995 RVW:** 5.12 **Recommended RVW:** 11.00
Workgroup Recommended New Value: 6.99

CPT Descriptor: Open treatment of tarsometatarsal joint dislocation, with or without internal or external fixation

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 28-year-old laborer falls from height sustaining tarsometatarsal dislocation. He undergoes open reduction with internal fixation.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of radiographs and examination of ipsi and contralateral extremity; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. The foot in such an injury is frequently severely swollen and may have soft tissue bruising. Careful evaluation of sensation and circulation must be done. Compartment syndromes of the foot can occur with this injury. Preoperative work also includes preoperative scrubbing; marking the patient for the planned incision; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: For open treatment of a tarsometatarsal dislocation, three longitudinal incisions are made on the dorsum on the foot, one dorsomedially over the first tarsometatarsal joint, one dorso midline over the lateral cuneiform and the intermetatarsal space of the second and third metatarsals, and one over the intermetatarsal space of the 4th and 5th metatarsals and over the cuboid. Subperiosteal and blunt and sharp dissection is carried out to reveal the dislocation sites. Very careful soft tissue handling must be employed due to the frequent soft tissue injury accompanying this injury. One then must assess whether there is marked comminution or just dislocation. The bases of the metatarsals are manually reduced using small instruments and dental picks to anatomically align the fracture fragments. Failure to do so will yield a stiff arthritic joint. The bones are held in place with guide wires going obliquely from the respective metatarsal bases into the cuneiforms and cuboid. With good bony stock proximally and distally, screws are placed over the guide wires to effect accurate reduction of the dislocation. The reduction is checked both by intraoperative radiograph evaluation and direct operative visualization, and adjustments made as necessary. Copious irrigation is then carried out, drains placed, if necessary, and the wounds are closed in layers.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and a cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including cast adjustments; care and removal of drains, if placed; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including adjustments and removal of cast; removal of sutures; ordering and assessing planned physiotherapy progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association; American Orthopaedic Foot and Ankle Society

Survey n:	223	RVW	PRE	INTRA	POST						
Response:	49		total min	total min	Day 1	ICU		Hosp. - Other		Office	
Rate %:	22%				total min	total min	# visits	total min	# visits	total min	# visits
low	5.50		60								
25th%	9.70		90								
med	11.00	60	100	30	0	0	33	2	75	4	
75th%	12.00		120								
high	20.00		180								

HARVARD DATA for surveyed service and key reference service(s):

Harvard 28615:	49	83	28	0	0	20	2	35	3.5
Harvard 27823:	47	117	21	0	0	51	4	50	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
10.90	27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip
10.86	28725	Subtalar arthrodesis

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
10.90	090	27823	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

In comparison to CPT 27823 (*Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip*), CPT 28615 (*Open treatment of tarsometatarsal joint dislocation, with or without internal or external fixation*) requires several incisions to expose the dislocation and perform fixation with screws/wires/plates. Also, more complex joint arrangements add to the intensity.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the Harvard study did not correctly estimate the intraoperative time for CPT 28615. This service is comparable to the key reference service 27823, with the additional intraoperative intensity due to more complex joint arrangement.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 21610 Global Period: 090 1995 RVW: 8.54 Recommended RVW: 20.00
Workgroup Recommended New Value: 16.00

CPT Descriptor: Costotransversectomy (separate procedure)

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 46-year-old female with a six-month history of back pain and X-ray evidence of a paravertebral mass undergoes a costotransversectomy for the decompression of the mass.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. Because selection of the correct site is critical, and intraoperative imaging sometimes difficult to interpret in the thoracic spine, it is often necessary to mark the appropriate rib and spinous process immediately preoperatively in coordination with a radiologist. Any unique surface or radiographic landmarks are sought and noted to assist with intraoperative localization. Arrangements are made for insertion and maintenance of a chest tube, should that become necessary. The intrinsic risks of spinal and chest surgery are discussed with patient and family along with any special risks presented by the patient's particular pathology, and consent obtained. The anesthesiologist is consulted preoperatively and informed of the possible needs for rapid hemodynamic and respiratory adjustments and provisions made for appropriate monitoring and lines. If indicated, arrangements are made for spinal cord monitoring. Provision for cell-saver and/or blood transfusion are made, as appropriate. The radiologist and/or technician who will assist with intraoperative imaging are consulted about the preoperative markings, the positioning, the draping, and any special equipment needed to provide adequate intraoperative imaging. The patient is positioned and prepped under the supervision of the surgeon to make sure that localization of the level of surgery is appropriate. This is facilitated by the use of skin markers and x-rays before the incision is made. Particular attention is given to arm positioning to protect from compression of nerves.

Intraoperative work: An incision is made, either vertically in the midline with a perpendicular incision along the rib to be excised, or vertically midway between the midline and the vertebral border of the scapula with a horizontal limb angling along the rib to be excised. The paravertebral muscles are divided horizontally. In the upper thoracic spine, more extensive muscle dissection may be necessary to mobilize the scapula. The costotransverse joints and transverse processes are cleared of muscle attachments. The periosteum of the rib is incised and stripped at least 8 cm laterally from the costotransverse joint. The pleura is protected and the rib is cut 8 cm from the joint with a bone cutting tool. The ligaments of the costotransverse joint are cut and the entire section of rib is removed. Intercostal neuro-vascular pedicles serve as landmarks to entry to the vertebral canal; they are ligated or protected as indicated for purpose of the procedure. Access to the intervertebral foramen is facilitated by removal of the transverse process with bone cutting tools. The pleura is protected with malleable retractors, the posterior mediastinum opened and the lateral surface of the vertebral body exposed. If the findings leave any doubt as to the appropriateness of exposure, imaging is used to reassess location. Any tumor, infection or other pathology encountered is attended by biopsy, decompression, and/or excision (which is coded separately). If indicated, a frozen section diagnosis is obtained and additional surgical measures provided as dictated by surgical findings. Drains are placed, a chest tube is inserted (if the pleura has been opened), and the muscles and skin are closed in layers.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings. A chest tube, if used, is connected to a pump to maintain lung expansion and arrangements are made to monitor its function. Postoperative provision for pain management, antibiotics, and other medication is made. The family is informed of the procedure, findings, and expectations. Chest X-rays are evaluated with or without chest tube to assess presence of pneumothorax. Hemodynamic indicators are followed and blood or fluids given as needed. Any drains used to evacuate the lesion are monitored, advanced, and removed. The chest tube is removed and lung expansion rechecked. Depending upon the preoperative stability of the spine, the pathology found, and the extent of bone removed, bracing, ambulatory assistance devices, and activity limitations are assessed, discussed, and provided for. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; North American Spine Society; American Spinal Injury Association

Survey n:	107	PRE	INTRA	POST							
Response:	25			Day 1 total min	ICU		Hosp. - Other		Office		
Rate %:	23%	RVW	total min		total min	total min	# visits	total min	# visits	total min	# visits
	low	12.00		45							
	25th%	15.00		120							
	med	20.00	75	180	18	18	1	50	3	50	3
	75th%	25.00		240							
	high	36.00		295							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 21610:	36	68	25	0	0	15	1.5	35	3.5
Harvard 63064:	80	241	36	0	0	88	8	37	2

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
23.23	63064	Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; single segment
14.21	63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
23.23	090	63064	Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; single segment

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The total work of the approach and exposure for CPT 63064 (*Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, hemiated intervertebral disk), thoracic; single segment*) is the same as for CPT 21610 (*Costotransversectomy (separate procedure)*). Additional intraoperative time is necessary for decompression of the spinal canal in CPT 63064.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel that is making this recommendation that the Harvard study did not correctly estimate the intraoperative time for patients requiring CPT 21610. Additionally, the postoperative work is underestimated and is more closely matched to CPT 63064.

To calculate an RVW for CPT 21610, that is "relative" to the current RVW for CPT 63064, but is adjusted for intraoperative time differences, one would multiply the intra-RVW* for 63064 by the additional intraoperative time ratio necessary for decompression of the spinal canal; and subtract this value from the total RVW for CPT 63064, as follows: $[13.63 \times (61/241) = 3.45]$; $[23.23 - 3.45 = 19.78]$

The recommended increased RVW, which is the survey median, reflects the similarities between CPT 21610 and CPT 63064 as discussed in the comparison to key references section and takes into account the difference in intraoperative time for decompression of the spinal canal as calculated above. This increased RVW also takes into account the similarity of IWP/UT for CPT 21610 and CPT 63064. The IWP/UT for CPT 21610, based on the recommended RVW of 20.00** is 0.0556. This compares with the IWP/UT of 0.0567 for CPT 63064, with an intra-RVW of 13.63.

It should be noted that a recommendation to increase the RVW for CPT 21610 was made in 1992. The following text presents HCFA's response to this request: "*Costotransversectomy* (CPT code 21610). The current work RVUs for this procedure are 6.30. The requested work RVUs were 11.46. There was considerable disagreement regarding the work of this service. Because of this disagreement, we considered keeping the current value. However, in light of the fact that the majority of reviewers recommended an increase, we have assigned work RVUs of 9.00 to this procedure. We believe this procedure involves slightly less work than the excision of a cervical rib (code 21615), which has work RVUs of 9.51." [Federal Register, Vol. 57, No. 228, November 25, 1992, pg 55940]

The decision to use CPT 21615 as a comparable reference service that involves more work was incorrect. By definition, costotransversectomy includes excision of a rib AND a transverse process of a vertebra (see intraoperative work description above).

Therefore, CPT 21610 cannot be less work than CPT 21615 (excision of a rib). If this assumption was based on the fact that the Harvard intraoperative time estimate for CPT 21610 was less than 21615, then the assumption was made in error because the Harvard reported intraoperative time of 68 minutes is based on the estimate of four general surgeons. In the Medicare population, 1994 NCH data show this procedure to be performed predominantly by neurosurgeons (32%), orthopaedics surgeons (18%), and thoracic surgeons (11%), with general surgeons representing less than 8% of the frequency. The AMA/RUC survey median intraoperative time of 180 minutes is based on the responses of orthopaedic surgeons who are members of the North American Spine Society and the American Spinal Injury Association, and who are familiar with the complexities and intricacies of this procedure.

Note: IWP/UT = intrawork per unit time

*The intraoperative RVW for 63064 is 13.63. This is equal to 67% of the total RVW, per Harvard's estimation of intra- vs. pre-/post-operative "work" (not time), as reported in Harvard Phase 3 - Final Report.

**The intraoperative RVW for 21610 is 10.00. This is equal to 50% of the total (recommended) RVW, per Harvard's estimation of intra- vs. pre-/post-operative "work" (not time), as reported in Harvard Phase 3 - Final Report.

Public Comments

30-Jun-95

Code: 21610

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Costotransversectomy (separate procedure)

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: ACS, ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
21610	50	0	0	50	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
21610	130	76	-23.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
21610	40.8	55.3	7.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
21610	general surgery	7.9
	general/family practice	13.2
	group practices	5.3
	internal medicine	5.3
	neurological surgery	31.6
	orthopedic surgery	18.4
	rheumatology	7.9
	thoracic surgery	10.5

Claims-Level Diagnosis Information:

Public Comments

30-Jun-95

	ICD9	Pct of Time Used	ICD9 Descriptor
21610			
	038	12.5	SEPTICEMIA
	428	12.5	HEART FAILURE
	510	12.5	EMPYEMA
	518	12.5	OTHER DISEASES OF LUNG
	869	12.5	INTERNAL INJURY TO UNSPECIFIED OR I

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
21610								
	AAOS		090	090	6.09	8.54	1.40	5.97

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
21610									
	AAOS	8.54	8.54	0.98	1.43	1.00	1.00	18.51	25

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
21610									
	AAOS	090	6.09		21	*	68		30

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
21610										
	AAOS	*	1.0		10	1.5	*	10	0.0	3.5

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
21610										
	AAOS	*	10	j	18.51	8.54	gs	3		0.045

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27428 Global Period: 090 1995 RVW: 10.68 Recommended RVW: 13.28
Accepted by Workgroup

CPT Descriptor: Ligamentous reconstruction (augmentation), knee; intra-articular (open)

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old recreational skier sustains a complete tear of the anterior cruciate ligament and tear of the medial collateral ligament of the knee. The anterior cruciate ligament is reconstructed through a mini-arthrotomy approach. The medial collateral ligament is treated non-operatively.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging and laboratory studies, with special attention to reports concerning ligament stability examination and review of MRI, if available; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes pre-operative scrubbing; supervision of positioning the patient supine with a special operative arm board; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary (i.e., drill guide devices and internal fixation devices for fastening grafts) are present and available in the operative suite. After administration of the anesthetic, the affected knee is carefully examined with ligament laxity recorded and correlations made with the office examination report. A tourniquet on the upper thigh may be used.

Intra-service work: An anterior incision is made over the knee. If a middle third patella tendon/bone autograft is to be taken the graft is now harvested using an oscillating saw to remove bone plugs from the patella and tibial tubercle in continuity with a 10 millimeter wide strip of central patella tendon. Heavy sutures are placed in each end of the bone plugs. An arthrotomy is then performed through the defect in the patella tendon by incising and retracting the fat pad. If hamstring autograft is to be used the semitendinosus and gracilis tendons are harvested with a tendon stripper. The tendons are then doubled and sutured together. A mini-arthrotomy is made through a small medial capsular incision to expose the knee joint. The knee joint is thoroughly inspected visually to identify the tear of the anterior cruciate ligament, inspect for loose bodies and inspect for any meniscal pathology. Torn menisci are excised or repaired (coded separately). The intercondylar notch is debrided with a rongeur with remnants of the torn anterior cruciate ligament being removed. The intercondylar notch is enlarged (a notch plasty) using osteotomes, curettes, rongeurs, gouges, or a power burr, as necessary.

The tibial tunnel is prepared using an appropriate drill guide to mark the anatomic center of the anterior cruciate ligament within the intercondylar notch. The extra-articular point of the drill guide is placed medial to the tibial tubercle and between the level of the tibial joint line and above the sartorius tendon. A guide pin is drilled through the drill guide from exterior to interior. It is very critical that the guide pin enter the knee joint in exactly the point desired by the surgeon. A reamer of appropriate size depending upon the diameter of the graft being used now overdrills the guide pin. The interior of the tibial tunnel and exit points both inside and outside the joint are chamfered with a rasp to insure a smooth bony tunnel.

Intra-service work (continued)

A point is selected far posterior in the intercondylar notch located approximately 7 millimeters anterior to the posterior wall of the rear of the intercondylar notch and lateral femoral condyle. A drill guide is used to place a guide pin at this pre-determined "isometric point" in the lateral superior portion of the intercondylar notch. This guide pin may be placed from inside the joint outward or from outside the joint inward, as appropriate. A reamer of appropriate size depending upon the diameter of the graft being used now overdrills the guide pin. The interior of the femoral tunnel and exit points both inside and outside the joint are chamfered with a rasp to insure a smooth bony tunnel. The tendon graft is passed from exterior through a bone tunnel then across the joint, exiting through the other bone tunnel. Holding the graft and maintaining tension on the sutures attached to each end of the graft, the knee is put through a range of motion to insure that there is no impingement by the femoral condyles or roof of the intercondylar notch on the graft, else the graft will become frayed, stretched and in time will fail. In addition, it must be carefully noted that there is no more than 2 millimeters of movement of the graft during range of motion of the knee. After range of motion assessment, the graft is secured on the femoral and tibial side according to the requirements of the tissue used for the graft and the desires of the surgeon (e.g., interference screws, staples, or sutures attached to bone). The knee is carefully tested for stability on the operating table prior to wound closure. A drain is placed. The wounds are closed in layers.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings, an immobilizing splint, and a Continuous Passive Motion (CPM) apparatus, as necessary. Postoperative work also includes monitoring patient stabilization in the recovery room, with special attention to monitoring of neurovascular status and function of the foot; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including continued monitoring of neurovascular function; adjustments to the splint and CPM apparatus; care and removal of drain; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; periodic assessment and adjustment of the splint; evaluation of periodic imaging reports, if needed; direct patient physiotherapy instruction by the surgeon; ordering and assessing adjunctive physiotherapy progress; and pain medication adjustments. The primary goal of current post-operative rehabilitation is the surgeon seeing to it that the patient maintains the ability to fully extend the operated knee. Not to do so frequently leads poor gait patterns resulting from knee flexion contractures or quadriceps extension deficits. Further, the surgeon orders active and assistive flexion exercises be stated immediately after surgery. These are continued and progressed as the post operative course proceeds. Lack of return of knee motion after surgery is a primary reason for poor patient satisfaction.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; American Orthopaedic Society for Sports Medicine

Survey n:	172	RVW	PRE	INTRA	POST						
Response:	41		total min	total min	Day 1	ICU		Hosp. - Other		Office	
Rate %:	24%				total min	# visits	total min	# visits	total min	# visits	
low	11.10		90								
25th%	13.00		120								
med	13.28	60	120	30	0	0	20	1	75	5	
75th%	14.50		160								
high	19.00		180								

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27428:	46	113	29	0	0	40	4	45	4.5
Harvard 29888:	41	127	22	0	0	27	2	47	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
13.28	29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
15.98	27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
13.28	090	29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 29888 (*Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction*) is the same service as CPT 27428 (*Ligamentous reconstruction (augmentation), knee; intra-articular (open)*), with the addition of endoscopic assistance. Pre- and post-operative work, time, and intensity are exactly the same. The intraoperative work of the two codes has come to differ only in that the arthroscope is used for visualization in CPT 29888, whereas an arthrotomy is employed in CPT 27428.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This increased RVW corrects a MFS anomaly. For this service, it is the opinion of the Orthopaedic RVS Advisory Panel recommending this RVW, that open procedure (CPT 27428) represents the same amount of total work as the arthroscopically assisted procedure (CPT 29888) and, therefore, should have the same RVW. The similar intraoperative times of the Harvard study for CPT 29888 confirm this rationale.

Public Comments

05-Jul-95

Code: 27428

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Ligamentous reconstruction (augmentation), knee; intra-articular (open)

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27428	50	0	50	100	50	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27428	85	56	-18.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27428	87.1	92.9	2.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27428	general/family practice	3.6
	orthopedic surgery	96.4

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27428							
	AAOS	090	090	9.74	10.68	1.10	10.68

Harvard Data:

Public Comments

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27428								
AAOS	10.68	10.68	1.10	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
27428								
AAOS	090	9.74		27	*	113		38

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27428									
AAOS	*	1.0	*	10	4.0	*	10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
27428									
AAOS	*	10			10.68	or	3		0.044

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27429 Global Period: 090 1995 RVW: 11.86 Recommended RVW: 17.75
Workgroup Recommended New Value: 14.67

CPT Descriptor: Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old recreational skier sustains a complete tear of the anterior cruciate ligament, tear of the medial collateral ligament and injury to the posterior lateral capsular ligaments of the knee. The anterior cruciate ligament is reconstructed through a mini-arthrotomy approach followed by an open repair of the posterior lateral corner of the knee and extra-articular anterior-lateral tenodesis.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging and laboratory studies, with special attention to reports concerning ligament stability examination and review of MRI, if available; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes pre-operative scrubbing; supervision of positioning the patient supine with a special operative arm board; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary (i.e., drill guide devices and internal fixation devices for fastening grafts) are present and available in the operative suite. After administration of the anesthetic, the affected knee is carefully examined with ligament laxity recorded and correlations made with the office examination report. A tourniquet on the upper thigh may be used.

Intra-service work: An anterior incision is made over the knee. If a middle third patella tendon/bone autograft is to be taken the graft is now harvested using an oscillating saw to remove bone plugs from the patella and tibial tubercle in continuity with a 10 millimeter wide strip of central patella tendon. Heavy sutures are placed in each end of the bone plugs. An arthrotomy is then performed through the defect in the patella tendon by incising and retracting the fat pad. If hamstring autograft is to be used, the semitendinosus and gracilis tendons are harvested with a tendon stripper. The tendons are then doubled and sutured together and a mini-arthrotomy is made through a small medial capsular incision to expose the knee joint.

The knee joint is thoroughly inspected visually to identify the tear of the anterior cruciate ligament, inspect for loose bodies and inspect for any meniscal pathology. If menisci are torn these are treated appropriately with excision or repair (coded separately). The intercondylar notch is debrided with a rongeur with remnants of the torn anterior cruciate ligament being removed. The intercondylar notch is enlarged (a notch plasty) using osteotomes, curettes, rongeurs, gouges, or a power burr, as necessary. The tibial tunnel is prepared using an appropriate drill guide to mark the anatomic center of the anterior cruciate ligament within the intercondylar notch. The extra-articular point of the drill guide is placed medial to the tibial tubercle and between the level of the tibial joint line and above the sartorius tendon. A guide pin is drilled through the drill guide from exterior to interior. [It is very critical that the guide pin enter the knee joint in exactly the point desired by the surgeon.] A reamer of appropriate size depending upon the diameter of the graft being used overdrills the guide pin. The interior of the tibial tunnel and exit points both inside and outside the joint are chamfered with a rasp to insure a smooth bony tunnel.

Intra-service work (continued)

A point is selected far posterior in the intercondylar notch located approximately 7 millimeters anterior to the posterior wall of the rear of the intercondylar notch and lateral femoral condyle. A drill guide is used to place a guide pin at this pre-determined "isometric point" in the lateral superior portion of the intercondylar notch. This guide pin may be placed from inside the joint outward or from outside the joint inward, as appropriate. A reamer of appropriate size depending upon the diameter of the graft being used overdrills the guide pin. The interior of the femoral tunnel and exit points both inside and outside the joint are chamfered with a rasp to insure a smooth bony tunnel. The tendon graft is passed from exterior through a bone tunnel then across the joint and then exiting through the other bone tunnel. Holding the graft and maintaining tension on the sutures attached to each end of the graft, the knee is put through a range of motion to insure that there is no impingement by the femoral condyles or roof of the intercondylar notch on the graft else the graft will become frayed, stretched and in time fail. In addition, it must be carefully noted that there is no more than 2 millimeters of movement of the graft during range of motion of the knee. After range of motion assessment, the graft is secured on the femoral and tibial side according to the requirements of the tissue used for the graft and the desires of the surgeon (e.g., interference screws, staples, or sutures attached to bone). The knee is carefully tested for stability on the operating table prior to wound closure. A drain is placed and the wounds are closed in layers.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings, an immobilizing splint, and a Continuous Passive Motion (CPM) apparatus, as necessary. Postoperative work also includes monitoring patient stabilization in the recovery room, with special attention to monitoring of neurovascular status and function of the foot; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including continued monitoring of neurovascular function; adjustments to the splint and CPM apparatus; care and removal of drain; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; periodic assessment and adjustment of the splint; evaluation of periodic imaging reports, if needed; direct patient physiotherapy instruction by the surgeon; ordering and assessing adjunctive physiotherapy progress; and pain medication adjustments. The primary goal of current post-operative rehabilitation is the surgeon seeing to it that the patient maintains the ability to fully extend the operated knee. Not to do so frequently leads poor gait patterns resulting from knee flexion contractures or quadriceps extension deficits. Further, the surgeon orders active and assistive flexion exercises be stated immediately after surgery. These are continued and progressed as the post operative course proceeds. Lack of return of knee motion after surgery is a primary reason for poor patient satisfaction.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; American Orthopaedic Society for Sports Medicine

Survey n:	172	PRE	INTRA	POST						
Response:	42			total min	total min	Day 1	ICU		Hosp. - Other		Office
Rate %:	24%	RVW	RVW			total min	total min	# visits	total min	# visits
	low	12.69		90						
	25th%	15.00		150						
	med	17.75	60	180	30	0	0	30	2	80
	75th%	19.92		198						
	high	25.50		240						

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27429:	48	136	29	0	0	45	4.5	45	4.5
Harvard 27427:	51	91	18	0	0	32	3	52	4
Harvard 29888:	41	127	22	0	0	27	2	47	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
13.28	29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
8.68	27427	Ligamentous reconstruction (augmentation), knee; extra-articular

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
13.28	090	29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
8.68	090	27427	Ligamentous reconstruction (augmentation), knee; extra-articular

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 29888 (*Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction*) is a very comparable service to CPT 27429 (*Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular*). CPT 29888 includes endoscopic assistance, while CPT 27429 includes extra-articular reconstruction, and consequently more intra-operative time and work.

The total work of CPT 27429 is equal to the work of CPT 29888 plus the intra-operative work of CPT 27427 (*Ligamentous reconstruction (augmentation), knee; extra-articular*), which is performed through a separate incision.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel recommending this RVW, that the Harvard study significantly underestimated the intraoperative time for CPT 27429. This is confirmed by the AAOS AMA/RUC large survey response which resulted in an estimated intraoperative time well above the Harvard estimate. In fact, even the estimate at the 25th percentile exceeded the Harvard estimate.

This increased RVW is approximately equal to the RVW for CPT 29888 (13.28) plus 51% of the RVW* for CPT 27427 (8.28), and is consistent with the total work components that comprise this service.

[13.28 + 4.22 = 17.50]

*The intraoperative RVW for 27427 is 4.22. [This is equal to 51% of the total RVW, per Harvard's estimation of intra- vs. pre-/post-operative "work" (not time), as reported in Harvard Phase 3 - Final Report.]

Public Comments

05-Jul-95

Code: 27429

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27429	0	0	100	100	0	0	0	0

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
27429	55	48	-6.2

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27429	90.8	83.3	-3.7

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
27429	cardiovascular disease	4.2
	orthopedic surgery	95.8

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27429							
AAOS		090	090	10.64	11.86	1.11	11.86

Harvard Data:

Public Comments

05-Jul-95

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27429								
AAOS	11.86	11.86	1.11	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
27429								
AAOS	090	10.64		29	*	136		38

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27429									
AAOS	*	1.0	*	10	4.5	*	10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27429									
AAOS	*	10			11.86	or	3		0.041

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 29889 Global Period: 090 1995 RVW: 10.76 Recommended RVW: 17.75
Workgroup Recommended New Value: 14.41

CPT Descriptor: Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 21-year-old skier tears the posterior cruciated ligament and requires arthroscopically aided ligament reconstruction.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging and laboratory studies, with special attention to reports concerning ligament stability examination and review of MRI, if available; consulting with the referring physician, if necessary, and other health care professionals; ordering preoperative supplemental steroid medication, if required; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes pre-operative scrubbing; supervision of positioning the patient, using a mechanical leg holder to support the upper thigh and facilitate movement and exposure of the knee; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary (i.e., drill guide devices and internal fixation devices for fastening grafts) are present and available in the operative suite; and supervising the application of a tourniquet on the upper thigh, if appropriate.

Intraoperative work: A bone/middle third patella tendon/bone autograft (when used) is harvested through an anterior incision using oscillating saw to remove bone plugs and contiguous middle third of patella tendon. (Fresh frozen Achilles tendon allograft may also be used but this requires the same degree of "back table" sterile preparation of the graft as does the patella tendon autograft). When autograft or allograft is used, it is included in the work of 29889 and, as stated, the same degree of careful graft preparation is required with both auto- and allograft.

After graft preparation is complete, then arthroscopic instruments are inserted into the knee with gravity or pump inflow through a superior arthroscopic portal and the arthroscope inserted from inferior lateral. Instrumentation for the procedure is brought in through an inferior medial patella portal. Video arthroscopy of the procedure with appropriate photographs and videotaping is frequently done. A 2 centimeter posterior medial skin incision is made that allows protection of the posterior neurovascular structures and through this incision one can monitor equipment working in the posterior aspect of the knee joint. This posterior medial incision begins at the level of the knee joint and extends distally approximately 2 centimeters. After opening the deep fascia, the surgeon's finger can be passed anterior to the medial head of the gastrocnemius muscle and neurovascular structures and posterior to the capsule of the knee joint. The posterior cruciate ligament fossa can be palpated through the capsule. The surgeon's finger is maintained in an extra-capsular position. If the surgeon wishes to avoid the necessity of a posterior medial incision, then intraoperative x-ray (C-arm fluoroscopy) must be used periodically during the procedure to insure proper placement of drill guides and drills to insure safety to the posterior neurovascular structures.

Intraoperative work (continued)

A diagnostic arthroscopy is included as part of this procedure, however, any meniscal pathology that is corrected is coded separately. A "Notch plasty" is performed to enlarge the intercondylar notch using a power burr. The posterior cruciate ligament stumps are debrided with a power instrument leaving remnants to serve as anatomic landmarks. The posterior cruciate ligament fossa is debrided and the posterior capsule is elevated from bone using a special curved knife, rasp and elevator. The surgeon's finger placed posterior medially insures that this latter dissection is done in its proper location and is done safely. This capsular elevation extends approximately 2 centimeters below the posterior tibial ridge. A drill guide is positioned so that the guide wire enters the anterior medial proximal tibia approximately 2 centimeters below the tibial tubercle and exits the tibial ridge posteriorly. The tip of the guide wire is monitored at all times by the surgeon's finger tip in the posterior medial incision. The tibial tunnel is made with a cannulated tibial reamer of the appropriate size. Soft tissue is carefully removed from the openings of the tunnel. A femoral tunnel is made by passing a guide wire from outside the knee using a drill guide to enter the knee joint at the center of the posterior cruciate ligament stump. The femoral tunnel is reamed to the same size as the graft material with all reaming debris evacuated with motorized instrumentation. A Luque wire is passed through the tibial tunnel into the back of the knee joint. The wire is then pulled out through the femoral tunnel. This may be a very difficult and time consuming portion of the procedure since the wire must pass sharply at the posterior aspect of the tibial tunnel at the rear of the knee and then round into the center of the knee joint where it must then be grasped with arthroscopic tools and pulled up into the femoral tunnel. A flexible rasp is then attached to the Luque wire and pulled through both tunnels in order to smooth the tissues around the tunnel edges. The graft material is attached to the end of the flexible rasp with traction sutures and then pulled into position. The graft material is then secured at the tibial tunnel and the femoral tunnels with interference screw or button and suture fixation. Care must be made prior to securing the graft that no impingement on the graft occurs from surrounding bone during the full range of motion. Further, there must be no bony impingement upon the graft in the intercondylar notch. Testing the knee for proper ligament stability must be done with adjusting the positioning of the graft if ligament stability is not achieved. An interarticular drain is placed and brought out through the skin through one of the arthroscopic portals. The posterior medial skin incision is closed in layers.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings, an immobilizing splint, and a Continuous Passive Motion (CPM) apparatus, as necessary. Postoperative work also includes monitoring patient stabilization in the recovery room, with special attention to monitoring of neurovascular status and function of the foot; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including continued monitoring of neurovascular function; adjustments to the splint and CPM apparatus; care and removal of drain; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; periodic assessment and adjustment of the splint; evaluation of periodic imaging reports, if needed; direct patient physiotherapy instruction by the surgeon; ordering and assessing adjunctive physiotherapy progress; and pain medication adjustments. The primary goal of current post-operative rehabilitation is the surgeon seeing to it that the patient maintains the ability to fully extend the operated knee. Not to do so frequently leads poor gait patterns resulting from knee flexion contractures or quadriceps extension deficits. Further, the surgeon orders active and assistive flexion exercises be stated immediately after surgery. These are continued and progressed as the post operative course proceeds. Lack of return of knee motion after surgery is a primary reason for poor patient satisfaction.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Arthroscopy Association of North America; American Orthopaedic Society for Sports Medicine

Survey n:	212	RVW	PRE	INTRA	POST						
Response:	48		total min	total min	Day 1	ICU		Hosp. - Other		Office	
Rate %:	23%				total min	# visits	total min	# visits	total min	# visits	
low	13.28		90								
25th%	15.74		120								
med	17.75	60	140	30	0	0	18	1	80	6	
75th%	19.69		180								
high	26.00		240								

HARVARD DATA for surveyed service and key reference service(s):

Harvard 29889:	52	132	25	0	0	5	0.5	40	4
Harvard 29888:	41	127	22	0	0	27	2	47	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
13.28	29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
19.69	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee replacement)

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
13.28	090	29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 29889 (*Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction*) involves more work in terms of depth and degree as compared with CPT 29888 (*Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction*). CPT 29889 frequently requires a secondary posterior incision to protect the popliteal artery and X-ray control is often necessary for accuracy in proper bone tunneling and graft placement. Postoperatively, CPT 29889 requires more visits for monitoring the progress of the patient's mobilization

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This increased RVW corrects a MFS anomaly. For this service, it is the opinion of the Orthopaedic RVS Advisory Panel recommending this RVW, and the survey confirms, that the Harvard study did not correctly estimate the intraoperative and postoperative time for patients requiring CPT 29889. The recommended increased RVW is higher than the RVW for the key reference service (CPT 29888) and takes into account the differences in total time and intraoperative intensity (due to the risk of injury and the need for protection of the popliteal neurovascular structures).

Public Comments

05-Jul-95

Code: 29889

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
29889	0	0	0	0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
29889	15	34	50.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
29889	46.7	64.7	9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
29889	group practices	5.9
	orthopedic surgery	94.1

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
29889							
	AAOS	090	090	11.11	10.76	0.97	10.76

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
29889								
AAOS	10.76	10.76	0.97	1.00	1.00	1.00		

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Htime	Notett	Imppt
29889								
AAOS	090	11.11		32	*	132		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hviedur	Icuvis	Offvis
29889									
AAOS	*	0.5	*	10	0.5	*	10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
29889									
AAOS	*	10			10.76	or	3		0.058

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 23395 Global Period: 090 1995 RVW: 12.42 Recommended RVW: 16.00
Accepted by Workgroup

CPT Descriptor: Muscle transfer, any type, shoulder or upper arm; single

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old worker with scapular disability and pain due to scapular winging undergoes pectoralis major transfer.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to review of neurovascular studies; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes pre-operative scrubbing; arranging for preoperative antibiotics and intra-operative blood product supply; supervision of positioning changes, where the patient is initially placed in a supine position until adequate general anesthesia is obtained, after which the patient is repositioned to about 30 to 45 degrees onto the left/right side to allow adequate access to the anterior shoulder as well as to the inferior pole of the scapula; supervision of prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite. Additionally, a pneumatic tourniquet is placed about the upper thigh of the leg and then the leg is elevated and prepped and draped.

Intraoperative work: Attention is first directed to harvesting of the semi-tendinosus gracilis graft using instruments placed on a separate table, not touching the main operating room table, in order to isolate the two fields. A 3 to 4 cm incision is made just inferior and medial to the tibial tubercle. Sharp dissection is employed through the subcutaneous tissues. Subcutaneous flaps are mobilized. Sartorius tendon and layer one are palpated. The semi-tendinosus and gracilis are palpated just underneath this. Next a longitudinal incision is made just above these palpable tendons and using a Metzenbaum scissor, layer one is split. A right angle clamp is then placed underneath each tendon and fascia, with extension to the posterior crural fascia. Using a concept tendon stripper, each of the tendons is harvested and dissected at their insertions into the tibia and then taken to the back table where muscle is removed from their proximal portions. The tendons are then woven together parallel to one another in order to increase the thickness of the graft, leaving sutures at each end so the tendon could be passed. The tendon is placed into a sterile saline bath, hemostasis is obtained with electrocautery, and the incision is closed with interrupted 0 and 2-0 Vicryl and a running subcuticular PDS suture for the skin reinforced with Steri-Strips. The tourniquet is deflated and this area of the field is redraped off. Gloves are changed and attention is directed to the exposure of the pectoralis major.

Intraoperative work (continued)

An approximately 8 cm incision is made just lateral to the coracoid process and curving down into the axilla over the pectoralis major. Sharp dissection is employed through the subcutaneous tissues down to the fascia overlying the pectoralis major. The subcutaneous flaps are then mobilized medially and laterally. The deltopectoral groove is then identified along with the cephalic vein. By digital palpation, the sternal and clavicular portions of the pectoralis major are identified. Bluntly, the two heads are separated from one another by placing the surgeon's finger underneath the pectoralis major inferior border and coming up through the pectoralis major medial to the tendon. A vessel loop is placed around this portion of the pectoralis major and is sharply and bluntly divided from the clavicular portion and traced laterally. Its fascial extensions are divided sharply. The biceps tendon is isolated and manually retracted medially and, using a #15 blade, the tendon is divided right off the lateral lip of the bicipital groove. The tendon of the semi-tendinosus gracilis graft is then taken and woven in a Pulvertaft fashion through the end of the pectoralis major. No. 1 Ethibond suture is used to secure it.

Attention is then directed to exposure of the inferior pole of the scapula. An approximately 3 cm incision is made over the palpable inferior pole of the scapula with the arm in forward flexion and adduction in order to bring the scapula forward. Sharp dissection is employed through subcutaneous tissues down to the latissimus. This is then split bluntly and, using electrocautery, the soft tissues are subperiosteally elevated off the inferior pole of the scapula. A Homan retractor is placed on the external and internal surface of the scapula. The lateral ridge or thickening of the scapula was palpated and, using a Hall, a burr hole is made just medial to this of sufficient size to allow passage of the graft. A looped No. 1 suture is then passed through this hole.. Blunt dissection is performed along the chest wall from this incision up to the incision for the pectoralis major. A soft tissue opening was dilated in order to allow the graft to be passed and the sutures in the end of the graft and pectoralis major are pulled down through the tunnel, pulling the pectoralis major down along the chest wall and out the inferior incision. These sutures, along with the graft, are then passed through the inferior pole of the scapula hole and by pulling up on them the scapula is pulled forward and against the chest wall. No. 1 Ethibond sutures are then used to secure the graft to itself after going through the hole in the anterior pole of the scapula such that it is a loop or stirrup through the anterior pole of the scapula sewn to itself. It is sutured along its length to reinforce the strength of this graft. Assessment is made to assure that the graft has sufficient tension in it with the arm in flex position as well as at the side, indicating that tension had been established with the tendon transfer. The wounds were both irrigated and closed using interrupted 0 and 2-0 Vicryl and a running 3-0 PDS suture for the skin reinforced with Steri-Strips.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings supervision of placement of a shoulder immobilizer and a cryocuff. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including adjustments to the shoulder immobilizer; supervision of the mobilization and ambulation of the patient; care of several operative wounds; ordering and reviewing radiographs; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and proper care of the immobilizer or splint, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging, muscle testing and physical therapy review, neurologic evaluation (EMG), and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; American Society for Surgery of the Hand; American Shoulder and Elbow Surgeons

Survey n:	214	RVW	PRE total min	INTRA total min	POST						
Response:	41				Day 1 total min	ICU		Hosp. - Other		Office	
Rate %:	19%					total min	# visits	total min	# visits	total min	# visits
low	12.00		75								
25th%	14.81		120								
med	16.00	60	160	30	0	0	30	2	75	5	
75th%	18.00		180								
high	20.77		225								

HARVARD DATA for surveyed service and key reference service(s):

Harvard: 23395	47	92	30	0	0	35	3.5	40	4.0
Harvard: 23462	54	104	27	0	0	34	3	51	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
14.62	23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer
12.69	23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff); chronic

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
14.62	090	23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The intraoperative work and time of CPT 23395 (*Muscle transfer, any type, shoulder or upper arm; single*) is greater than CPT 23462 (*Capsulorrhaphy, anterior, any type; with coracoid process transfer*), because of the mobilization and transfer of a major muscle with its neurovascular pedicle. Additionally, the postoperative care of the patient is greater for CPT 23395 due to the necessary continued assessment of muscle functioning and neurovascular status and necessary bracing/casting.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This RVW is slightly higher than the key reference service (CPT 23462) and reflects the differences in intraoperative and postoperative care, as discussed in the comparison to key references section above.

It is the opinion of the Orthopaedic RVS Advisory Panel presenting this recommendation, and the AMA/RUC survey confirms, that the Harvard study underestimated the intraoperative time for all the different components of this service, and underestimated (through prediction) the postoperative care necessary to monitor most patients requiring this service.

Public Comments

Code: 23395

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Muscle transfer, any type, shoulder or upper arm; single

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
23395	50	0	0	50	0	0	0	50

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
23395	60	108	34.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
23395	88.3	81.5	-3.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
23395	orthopedic surgery	98.1

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
23395	AAOS		090	090	11.08	12.42	1.12	12.42

Harvard Data:

Public Comments

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
23395								
AAOS	12.42	12.42	1.12	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
23395								
AAOS	090	11.08		27	*	92		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
23395									
AAOS	*	1.0	*	10	3.5	*	10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
23395									
AAOS	*	10			12.42	or	3		0.074

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27397 Global Period: 090 1995 RVW: 9.33 Recommended RVW: 12.00
Workgroup Recommended New Value: 10.53

CPT Descriptor: Transplant, hamstring tendon to patella; multiple

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 9-year-old boy with cerebral palsy, spastic diplegia, and a progressive gait disturbance undergoes bilateral multiple hamstring tendon transfer to the patella.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies, with special attention to review of seizure medication dosing (if applicable) and hematological status; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes pre-operative scrubbing; arranging for intra-operative pneumatic tourniquet; supervising positioning, prepping and "free leg draping" of the patient's legs, well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: This procedure involves the transfer of the medial hamstrings, usually the gracilis and semitendinosus to the medial border of the patella or the quadriceps mechanism. This is usually performed under tourniquet control. After the patient is positioned supine on the operating table and the leg is exsanguinated with an Esmark bandage and a pneumatic tourniquet is inflated to an appropriate pressure, an incision is made along the medial aspect of the knee. The tendons of the gracilis and semitendinosus tendons are identified as close to their distal insertion as possible and divided. The semimembranosus may need to be recessed if it is contracted. Care is taken to avoid injury to the saphenous nerve. Through a lateral incision, the biceps femoris tendon is released from its attachment to the fibular head. The peroneal nerve must be protected and the fibular collateral ligament left uninjured. The tendons are mobilized proximally through a second incision so that they may be redirected anteriorly in a relatively straight line. With the knee in extension the patella is exposed through a third incision and a tunnel is made beneath the periosteum of the superomedial aspect. This is done through two parallel incisions followed by subperiosteal dissection. The hamstring tendons are then routed through this periosteal tunnel. They are then folded back onto themselves and repaired with interrupted nonabsorbable sutures. The tendons may also be woven into the quadriceps mechanism if there is insufficient length. The wound is then irrigated and the subcutaneous tissues and skin closed in layers. The wound may need to be drained. Steri strips are applied to the skin edges. This same procedure may then be performed on the opposite side.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and long leg cast. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular status and hematologic status; care and removal of Hemovac drain; assessing the need for a possible cast change; supervision of physiotherapy; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and planned physiotherapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures and cast; ordering new orthoses; assessing physiotherapy progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Pediatric Orthopaedic Society of North America

Survey n:	134	RVW	PRE	INTRA	POST						
Response:	33		total min	total min	Day 1	ICU		Hosp. - Other		Office	
Rate %:	25%				total min	# visits	total min	# visits	total min	# visits	
low	8.50		40								
25th%	10.00		80								
med	12.00	60	120	30	0	0	30	2	60	4	
75th%	12.75		120								
high	21.00		210								

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27397:	44	97	29	0	0	35	3.5	40	4
Harvard 23412:	53	93	25	0	0	23	2	49	4
Harvard 26498:	44	114	24	0	0	11	1	54	4
Harvard 27691:	52	109	22	0	0	35	3	52	4
Harvard 27692:	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
12.69	23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff); chronic
7.97	27394	Lengthening of hamstring tendon; multiple, one leg

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
12.69	090	23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff); chronic
13.55	090	26498	Tendon transfer to restore intrinsic function; all four fingers
7.33	090	27396	Transplant, hamstring tendon to patella; single
9.25	090	27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); anterior tibial or posterior tibial through interosseous space
1.87	ZZZ	27692	Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 23412 (*Repair of ruptured musculotendinous cuff (eg, rotator cuff); chronic*) involves similar complex exposure, but less time than CPT 27397 (*Transplant, hamstring tendon to patella; multiple*).

CPT 26498 (*Tendon transfer to restore intrinsic function; all four fingers*) involves less exposure and depth than CPT 27397, but includes "multiple" tendon transfers.

CPT 27691 (*Transfer or transplant of single tendon (with muscle redirection or rerouting); anterior tibial or posterior tibial through interosseous space*) and CPT 27692 (*Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon*), taken together approximated the total work of CPT 27397, except the latter service involves separate incisions.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

It is the opinion of the Orthopaedic RVS Advisory Panel presenting this recommendation, and the AMA/RUC survey confirms, that the intraoperative time for CPT 27397 was underestimated in the Harvard study. CPT 27397 (multiple tendon transplant) is also more work than CPT codes 27691/27692 taken together as discussed in the comparison to key reference services section above. The combined RVW for these codes is 11.12, and, as such the RVW for CPT 27397 should be greater. CPT 27397 (multiple tendon transplant) takes as much time as CPT 26498 (tendon transfer, four fingers) because of exposure and depth, but may not be as intense and, as such, should reasonably be valued less than CPT 26498.

The current RVW for CPT 27397 represents an anomaly in the MFS when compared with other services involving similar exposure and tendon transfer/transplant as presented. The recommended increased RVW accurately places the work value for CPT 27397 "relative" to similar procedures in the MFS.

Public Comments

27-Sep-95

Code: 27397

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Transplant, hamstring tendon to patella; multiple

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey:

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

Trends Analysis -- Site of Service:

Trends Analysis -- Specialty Mix:

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27397							

Public Comments

27-Sep-95

AAOS	090	090	8.46	9.33	1.10	9.33
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Harvard Data:

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27397								
AAOS	9.33	9.33	1.10	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
27397								
AAOS	090	8.46		25	*	97		38

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27397									
AAOS	*	1.0	*	10	3.5	*	10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27397									
AAOS	*	10		.	9.33	or	3		0.041

Public Comments

27-Sep-95

5Yr/MBgRpt

1

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 25115 Global Period: 090 1995 RVW: 6.26 Recommended RVW: 9.00
Workgroup Recommended New Value: 8.00

CPT Descriptor: Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female with rheumatoid arthritis and marked flexor tendon synovitis at the wrist, carpal tunnel, and distal forearm requires surgical excision of all diseased synovium.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to surface anatomy landmarks and suspected area(s) of pathologic materials; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes pre-operative scrubbing; arranging for intra-operative materials for taking cultures; supervision of the patient positioning and application of special arm operating board; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: An incision is made on the palmar aspect of the distal forearm, wrist, and extending over the carpal tunnel in the mid third of the palm. The incision is then carried through the subcutaneous fat, care is taken to incise the distal antebrachial fascia and to protect and preserve the palmar cutaneous branches of the median and ulnar nerves. An incision is made through the subcutaneous fat in the palm down to the palmar aponeurosis, which is then incised longitudinally. The ulnar nerve and artery are noted and protected in Guyons canal. The transverse carpal ligament is identified, a hemostat placed carefully in the carpal tunnel immediately under the transverse carpal ligament, and the transverse carpal ligament is then incised carefully fiber by fiber along its ulnar aspect under direct vision looking for any branches of the ulnar or medial nerve penetrating the ligament prior to completely incising this ligament. The hypertrophic and bulging and invasive synovium is carefully and tediously removed from about each of nine flexor tendons, individually taking care to preserve each tendon. Cultures of any pathologic fluid, whether it is abnormal tissue, pathologic deposits, or rice bodies that might be present are removed. Specimens are taken for aerobic, anaerobic, fungal and microbacterial cultures. This pathological material is stripped away from the tendons using a combination of scissors, rongeur, and knife. If ruptured tendons are found they may be repaired (coded separately). The median nerve is inspected and protected throughout this procedure. After thorough exploration of the carpal tunnel and the region of the flexor tendons, evidence of invasion of the material in to the wrist joint is noted. Opening and debridement of the wrist joint may be necessary (and coded separately). Material from the tendons is often adherent and has to be stripped away from each tendon individually. The tourniquet is then deflated, hemostasis is obtained, a drain may be inserted, the wound is closed in layers, closing the subcutaneous tissue and then the skin.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and splint. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including; care, adjustment, and removal of the splint; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and planned therapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; ordering and assessing therapy progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments. Critical wound inspection must be done to ensure no skin slough or circulatory embarrassment occurred as a result of the extensive surgical dissection. The physician orders orthotic supports for the wrist and directs a post operative physical therapy program to recover finger, hand and wrist range of motion and function.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; American Society for Surgery of the Hand

Survey n:	108	RVW	PRE total min	INTRA total min	POST						
Response:	28				Day 1 total min	ICU		Hosp. - Other		Office	
Rate %:	26%					total min	# visits	total min	# visits	total min	# visits
low	7.00										
25th%	7.37										
med	9.00	45	90	30	0	0	0	0	60	4	
75th%	10.38										
high	14.00										

HARVARD DATA for surveyed service and key reference service(s):

Harvard 25115:	30	73	22	0	0	25	2.5	40	4.0
Harvard 25260:	43	50	23	0	0	10	1	54	5

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
7.33	25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
11.80	25023	Decompression fasciotomy, forearm and/or wrist; with debridement of nonviable muscle and/or nerve

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	Global	CPT	Descriptor
7.33	090	25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 25260 (*Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle*) for ONE tendon requires less intraoperative time and effort than CPT 25115 (*Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors*) which involves NINE tendons that undergo synovectomy. Additionally, if necessary, carpal tunnel release also adds to the intraoperative time and work of CPT 25115. The need to identify and protect the median nerve adds to the complexity and intensity of CPT 25115.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This RVW is higher than the key reference service (CPT 25260) and reflects the differences in intraoperative time and intensity, as discussed in the comparison to key references section above.

Additionally, it should be noted that the initial valuation of CPT 25115, which was based on the Harvard study, underestimated the intraoperative time of this service.

Public Comments

05-Jul-95

Code: 25115

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors

Reference Set (y/n): **Global Period:** 090 **Frequency:** **Impact:**

Source: **Year:** **Public Comment Letter:** AAOS

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
25115	47.7	8.6	6.3	65.6	9.4	0	1.6	3.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
25115	4071	4646	6.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
25115	15.4	12.7	-1.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
25115	general surgery	3.6
	orthopedic surgery	75.3
	plastic surgery	16.4

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
25115	AAOS		090	090	6.53	6.26	0.96	6.26

Public Comments

05-Jul-95

Harvard Data:

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
25115								
AAOS	6.26	6.26	0.96	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
25115								
AAOS	090	6.53		17		73		25

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
25115									
AAOS		1.0	*	10	2.5		10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
25115									
AAOS		10		.	6.26	or	3		0.041

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 26442 Global Period: 090 1995 RVW: 6.10 Recommended RVW: 10.00
Workgroup Recommended New Value: 7.45

CPT Descriptor: Tenolysis, simple, flexor tendon; palm AND finger, each tendon

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male requires a single finger and palmar tenolysis of adhesions after a flexor tendon repair in no-man's land.

Preoperative work begins after the decision to operate is made, from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to location of scarring from injury and previous surgery; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes pre-operative scrubbing; supervision of patient positioning with a special operative arm board; supervising prepping and draping the patient, as well as ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite.

Intraoperative work: An incision is made through the skin taking care to follow and note previous scars from the previous flexor tendon repair. The incision is made from at least the distal portion of the middle phalanx along the palmar aspect of the finger, proximal to the mid-third of the palm. Care is taken to tediously dissect (using loop magnification) the skin from the underlying scar tissue. The incision is carried down to the flexor tendon sheath. The nerve and artery on either side of the finger are dissected out carefully and protected throughout the procedure. The digital arteries and nerves may be adherent to a scar from the previous surgery, as well as adherent to the flexor tendon sheath. The location of the scarring is noted, and the flexor tendon sheath is entered, taking care to identify the area of the fourth annular and the second annular pulleys. The flexor tendon sheath is entered outside these pulleys. Initially, the dissection is done where there is little or no scarring proceeding from the nearly normal into the dense area of scar. The scar tissue is removed from the superficial surface of the flexor tendon. The profundus tendon which had been repaired is identified and, using a combination of knife, scissors, freers, and special dissectors, the profundus tendon is separated from the superficialis tendon. (If both the superficialis and profundus tendon each require tenolysis, they are coded separately.) The single tendon is then freed up. The profundus tendon, for instance, is freed up under the scar, separated from under the closely adherent first, fourth, and second annular pulleys (tendon sheath and bone). The tendon is pulled-on to see if it flexes the proximal interphalangeal and distal interphalangeal joints. If full flexion is not obtained (provided the joint allows full flexion), then additional dissection is done proximally and/or distally. The profundus tendon is identified proximal to the first annular pulley in the palm and freed up from any scar tissue. It is pulled-on to check the amount of excursion of the tendon and how much flexion and extension are obtained. The procedure is somewhat tedious and surgery is not stopped until, by pulling on the flexor tendon in the palm, full flexion of the finger can be obtained.

Another incision is made at the wrist flexion crease, and the profundus tendon identified to this finger after dissecting through the fascia, and pulling on this tendon to make sure that full flexion is obtained. If it is not obtained, then further dissection of the tendon and freeing up of scar tissue and adhesions is done. Once there is full excision of this tendon, and as full a range of motion as possible, then the tourniquet is let down, and hemostasis obtained. The circulation is checked in the finger and the skin closed with multiple sutures.

Postoperative work begins after skin closure in the operating room and includes application of sterile dressings and splint. Postoperative work also includes monitoring patient stabilization in the recovery room; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring neurovascular function of the hand; adjustments of splint; ordering and assessing immediate postoperative therapy; and antibiotic and pain medication management;. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care and planned therapy, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; assessment of therapy progress; evaluation of periodic imaging reports, if needed; and antibiotic and pain medication adjustments. Critical wound inspection must be done to ensure no skin slough or circulatory embarrassment occurred as a result of the surgical dissection. The physician orders orthotic supports for the finger and hand and directs a post operative physical therapy program to recover finger, and hand range of motion and function.

SURVEY DATA:

Specialty(s): American Academy of Orthopaedic Surgeons; American Society for Surgery of the Hand

Survey n:108
 Response:28
 Rate %:26%

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
					total min	# visits	total min	# visits	total min	# visits
low	5.00		35							
25th%	7.35		64							
med	10.00	45	90	30	0	0	0	0	80	5
75th%	11.60		98							
high	14.00		120							

HARVARD DATA for surveyed service and key reference service(s):0

Harvard 26442:	37	63	20	0	0	10	1	35	3.5
Harvard 26390:	49	70	22	0	0	14	1	45	4

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
7.33	25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
11.80	25023	Decompression fasciotomy, forearm and/or wrist; with debridement of nonviable muscle and/or nerve

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
8.73	090	26390	Flexor tendon excision, implantation of plastic tube or rod for delayed tendon graft, hand or finger

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The intraoperative work of CPT 26390 (Flexor tendon excision, implantation of plastic tube or rod for delayed tendon graft, hand OR finger) is less than CPT 26442 (Tenolysis, simple, flexor tendon; palm AND finger, each tendon) in terms of depth and degree of procedure.

The two procedures are however similar in that they each require exposure of the flexor tendon sheath and its contents.

Both procedures require the preservation of the pulley system, but CPT 26442 requires the meticulous dissection of one flexor tendon from another and the pulleys.

CPT 26390 includes the excision of the flexor tendons which requires lysis of adhesions as in 26442, but in a less meticulous fashion.

The neurovascular structures must be protected in each procedure.

CPT 26390 involves either the finger OR the palm while CPT 26442 includes the finger AND palm.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This RVW is slightly greater than the key reference service (CPT 26390) and reflects the greater total work of CPT 26442, as discussed in the comparison to key references section above.

It is the opinion of the Orthopaedic RVS Advisory Panel presenting this recommendation, and the AAOS AMA/RUC survey confirms, that the Harvard study underestimated the total time for all the different components of this service.

Public Comments

05-Jul-95

Code: 26442

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Tenolysis, simple, flexor tendon; palm AND finger, each tendon

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
26442	20	0	25	80	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
26442	364	338	-3.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
26442	21.4	11.2	-5.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
26442	orthopedic surgery	76.3
	plastic surgery	21.9

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
26442							
	AAOS	090	090	5.99	6.10	1.02	6.10

Harvard Data:

Public Comments

05-Jul-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
26442								
AAOS	6.10	6.10	1.02	1.00	1.00	1.00	.	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
26442								
AAOS	090	5.99		22	*	63		30

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
26442									
AAOS	*	0.5	*	10	1.0	*	10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
26442									
AAOS	*	10			6.10	or	3		0.050

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 27894 **Global Period:** 090 **1995 RVW:** 7.64 **Recommended RVW:** 9.13

CPT Descriptor: Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve

Source and Summary of Comment to HCFA on this service: The original comments submitted by AAOS to HCFA were reviewed but not accepted in entirety by the AMA/RUC Research Subcommittee. AAOS was allowed to withdraw the original comments (representing approximately 1,300 codes) and submit a modest list of 83 codes to survey during the MFS five-year review. This list of misvalued codes was prepared by AAOS and 11 national orthopaedic subspecialty organizations.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old female, who had been trapped under rubble of a collapsed building for 24 hours, presents to the emergency department with one leg swollen and very painful with elevated tissue pressures of all compartments. Fasciotomy and debridement of devitalized muscle is performed as an emergency procedure.

Preoperative work that occurs within 24 hours of the operation involves the initial presentation and assessment of the patient for this emergency procedure. This includes the history and examination of the patient under emergency conditions. Evaluation for musculoskeletal injuries, neurovascular impairment of the extremity, and the general metabolic, renal and circulatory status of the patient must all be done upon initial evaluation of the patient. All pertinent laboratory and imaging studies must be ordered and reviewed promptly. Rapid measurement of pressures within all four compartments of the leg is done with a pressure transducer introduced with a needle into the muscle compartment. Rather than absolute tissue pressure measurement, considering the difference (ΔP) between tissue pressure and mean arterial pressure is a better indicator of tissue ischemia. The patient and family are thoroughly counseled as to the significance of the clinical problem which might result in amputation (at worst) or loss of muscle tissue and permanent ambulatory disability (at best). Other preoperative tasks involve scheduling an emergent surgery, making sure that appropriate preoperative antibiotics and IV fluids are being administered, as well as providing necessary tetanus prophylaxis. Direct communication with the anesthesiologist and possibly a vascular surgeon (should arterial repairs be necessary) is necessary prior to taking the patient to the operating room. The surgeon positions the patient on the operating table and supervises the skin preparation and applies surgical draping to allow complete access to the entire circumference of the leg from mid thigh to toes. Compartment tissue pressure measurements may be repeated at this time.

Intraoperative work: Release (decompression fasciotomy) of all the leg compartments is most commonly performed through two incisions.* This must be an extensive decompression unlike what is done for exercise-related compartment syndrome.

[*In previous years, a one-incision approach, with fibulectomy, was performed to gain access for decompression and debridement of all four compartments of the leg. Experience and patient outcome analysis has caused an abandonment of this one-incision technique for several reasons:¹ One incision is less likely to provide adequate decompression of compartments. It adds significant soft tissue damage to an already compromised limb by requiring circumferential fibular dissection. Reconstruction of the leg is compromised with fibulectomy in circumstances of a tibial fracture. Complaints often arise of muscle weakness affecting extensor and flexor muscle groups (superimposed upon any disability resulting from the debridement). Ankle instability often occurs as a result of upward displacement of the lateral malleolus remaining following a fibulectomy done within 8 cm. of the distal tip of fibula.²]

At operation, the two incisions, medial and lateral, are placed well around to the sides of the limb and over muscle so that split-thickness skin coverage will be possible if necessary. A lateral incision is made over the intermuscular septum between anterior and lateral compartments, and is long enough to allow access to the entire length of the compartments. It should extend from just distal to the head of the fibula to 5 cm proximal to the lateral malleolus. The superficial peroneal nerve must be located and protected. Both compartments are released by undermining the skin anteriorly and posteriorly and then longitudinally incising the fascia over each compartment separately. Another incision is made just medial to the border of the tibia, with identification and protection of the saphenous vein and nerve. The fascia is released from its insertion to the periosteum of the tibia, and bluntly dissected around the tibia posteriorly to identify and release the deep posterior compartment. This may require subperiosteal release of a separate fascial connection to the tibia. It is important to protect the posterior tibial artery, peroneal artery, and posterior tibial nerve and vein which lay in direct line to the exposure of the deep compartment. Muscle viability in all compartments is assessed by color, consistency, bleeding and contractility. Debridement of devitalized muscle and or nerves is performed as necessary. Compartment pressures are generally re-measured in the operating room to verify release of all four compartments. The wounds are generally left open and covered with fine mesh sterile dressing. The leg is placed in a plaster splint.

Postoperative work begins after application of sterile dressings and leg splint to prevent foot drop. Pulse oximeters are sometimes used in addition to careful monitoring of the circulation, sensation and motor function of the limb in the recovery room. The family is counseled in regards to the extent of the operative findings and if appropriate the possible need for returns to the operating room or possible future amputation. The operative note is dictated and orders are written. Monitoring of urinary output, kidney function, maintaining adequate intravenous fluid intake, antibiotic administration and hemoglobin levels are imperative. Returning the patient to the operating room within 5 days for wound inspection and closure or skin grafting is necessary (billed separately). The surgeon directs physical therapy in protected ambulation with crutches or a walker as well as the exercise to prevent joint contracture. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Frequent dressing changes and wound inspection are necessary during the post discharge period. Careful follow-up is necessary to identify and promptly treat any deformity that may develop as a result of muscle contracture. Permanent walking aids (orthotics, special shoes, or braces) are frequently necessary and are prescribed by the surgeon.

¹Browner BD, Jupiter JB, Levine AM, and Trafton P. Skeletal Trauma. Chapter 51, pp 1799-1800.

² Babhulkar SS, Pande KC, Babhulkar S. "Ankle Instability after Fibular Resection." J Bone Joint Surgery (Br) 1995; 77-B: 258-261.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association

Survey n: 179
 Response: 35
 Rate %: 20%

	RVW	PRE	INTRA	POST						
		total min	total min	Day 1	ICU		Hosp. - Other		Office	
				total min	total min	# visits	total min	# visits	total min	# visits
low	7.00		45							
25th%	10.00		65							
med	11.80	60	90	30	0	0	90	6	78	5
75th%	12.10		103							
high	15.00		180							

HARVARD DATA for surveyed service and key reference service(s):

Harvard 27894:	n/a									
Harvard 25023: (ortho surg)	52	100	28	0	0	70	7	60	5	
Harvard 27600: (gen surg)	41	27	17	0	0	33	3	35	3	
Harvard 27601: (gen surg)	41	28	17	0	0	33	3	36	3	
Harvard 27602: (gen surg)	44	45	20	0	0	40	4	41	4	
Harvard 27892:	n/a									
Harvard 27893:	n/a									

Note: Harvard Pre- and Postoperative times are "predicted," not surveyed.

Reference services cited most frequently by survey respondents (Please note that the survey respondent may have estimated an RVW for the surveyed service that is more or less than the reference service chosen):

1995 RVW	CPT	Descriptor
11.80	25023	Decompression fasciotomy, forearm and/or wrist; with debridement of nonviable muscle and/or nerve
10.51	27758	Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage

KEY REFERENCE SERVICE(S) cited for use by AAOS RVS ADVISORY PANEL:

1995 RVW	CPT	Descriptor
11.80	25023	Decompression fasciotomy, forearm and/or wrist; with debridement of nonviable muscle and/or nerve
5.02	27600	Decompression fasciotomy, leg; anterior and/or lateral compartments only
4.98	27601	Decompression fasciotomy, leg; posterior compartment(s) only
6.63	27602	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)
6.10	27892	Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve
6.06	27893	Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and postoperative time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 27894 involves similar intraoperative exposure, debridement, and decompression as CPT 25033. Preoperative work for CPT 27984 is also similar to CPT 25033. Postoperative care for CPT 27894, involving recovery of weightbearing joints, may be greater than for CPT 25033.

CPT 27894 is a procedure that involves identification and debridement of nonviable muscle and/or nerves, in addition to decompression fasciotomy of compromised muscle compartments of the leg. Reference services 27600, 27601, and 27602 involve only the decompression fasciotomy, and as such, comprise a lesser degree of decision making, require less experience, and much less surgical time and effort than CPT 27894.

CPT 27984 requires twice the intraoperative time as compared with CPT 27602 (Decompression fasciotomy of the same compartments addressed in 27984) and significantly more intensity since the patient requiring CPT 27984 is always a trauma case that presents as a more critically ill patient than a patient requiring CPT 27602. Additionally, a patient requiring CPT 27894 has a much greater degree of postoperative morbidity due to muscle loss, adding to the postoperative intensity of care.

CPT 27984 represents the combination of CPT 27982 and 27983. The latter two procedures are each performed through a separate incision, while the former is performed through two incisions. Further, patients in need of either CPT 27982 or CPT 27983 have less soft tissue damage and, as such, are less susceptible to the metabolic abnormalities (preoperative) and the degree of postoperative disability as seen in patients requiring CPT 27894. Consequently, postoperative care for a patient requiring CPT 27984 is greater than for a patient requiring CPT 27982 or 27983.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A revised RVW of 9.13 is recommended for CPT 27894.

The results of the AAOS/RUC 5-year review survey for CPT 27984 indicate this service requires similar intraoperative work and slightly more postoperative work than CPT 25023, and, as such, the survey median RVW of 11.80 was originally recommended to set an appropriate value for CPT 27894 "relative" to CPT 25033. The RUC Workgroup rejected this rationale.

The Orthopaedic RVS Advisory Panel has reconsidered the original recommendation in light of the comments of the RUC Workgroup, who felt there was a correct rank order currently among CPT codes 27892, 27893, and 27894. While we also agree with the order, we disagree with the magnitude of difference in RVWs between CPT 27894 and the other two fasciotomy with debridement procedures, CPT 27982 and 27983. It should also be noted that the magnitude of difference in work between CPT 27984 and CPT 27982 or 27983 is greater than the magnitude of difference in work between CPT 27602 and CPT 27600 or 27601. CPT 27984 is an infrequently performed procedure that is restricted to patients with limb-threatening conditions primarily due to the extensive death of muscle in multiple leg compartments. Necrosis of tissue in multiple compartments of a limb requires complex decision-making about amputation versus limb salvage, and intense interaction with the patient and family to a greater degree than patients requiring CPT 27892 or 27893 (or 27600, 27601, 27602).

Rationale (continued):

As presented in the relationship to key reference services section above, CPT 27984 represents the sum of CPT 27982 plus CPT 27983, each of which are performed through a separate incision. CPT 27894 involves a significantly greater degree of work/intensity than either CPT 27892 or 27893 because it involves a potentially limb-threatening injury. The patient may be at risk of hypovolemic shock and myoglobin-induced renal failure and must be monitored closely. Further, because of the greater amount of soft tissue damage, postoperative care for patients requiring CPT 27984 is greater than for patients requiring CPT 27982 or 27983.

Given this discussion, it is still the opinion of the Orthopaedic RVS Advisory Panel that, without the assistance of surveyed service time estimates, the initial valuation of CPT 27894 by HCFA in 1992 did not correctly reflect the work involved in providing this service relative to the key reference services cited above. Additionally, it is likely that the one-incision technique was considered, instead of only the two-incision approach (which is now the norm), resulting in an underestimation of time and work when 27602 was valued in the Harvard study.

In comparing the percentage difference in RVW's (see Table 1 below) between the decompression fasciotomy alone and the paired decompression fasciotomy AND debridement codes one finds: a +22% between CPT codes 27600 and 27892; a +22% difference between CPT codes 27601 and 27893; BUT ONLY a +15% difference between CPT codes 27602 and 27894. This latter difference does not take into account the clinical nature of the difficult limb- and (sometimes) life-threatening condition present in a patient who requires CPT 27894 as discussed above.

Table 1: Comparison of 1995 RVWs and Intra-service Time Estimates for Selected Services

Decompression fasciotomy, leg;	WITHOUT debridement of muscle/nerve	WITH debridement of muscle/nerve	% RVW difference
Anterior and/or lateral compartments ONLY	CPT 27600 RVW = 5.02 Intra-time = 27 minutes*	CPT 27982 RVW = 6.10 Intra-time = not surveyed	22%
Posterior compartment(s) ONLY	CPT 27601 RVW = 4.98 Intra-time = 28 minutes*	CPT 27983 RVW = 6.06 Intra-time = not surveyed	22%
BOTH anterior/lateral AND posterior compartments	CPT 27602 RVW = 6.63 Intra-time = 45 minutes*	CPT 27984 RVW = 7.64 Intra-time = 90 minutes**	15%

*Harvard RBRVS Study time estimates.

** AAOS RUC 5-year review survey estimate.

The recommended RVW of 9.13 for CPT 27894 is based on a multiple procedure calculation using the RVW's for CPT codes 27983 and 27982 [$6.10 + 50\%(6.06) = 9.13$]. This RVW represents a +38% difference as compared to CPT 27602. We believe this difference is reasonable and appropriate when compared to the +22% difference for the other paired procedures because of the clinical details and changes in operative technique as described above.

Public Comments

05-Jul-95

Code: 27894

1995 RVUs:

Recommended RVUs:

Ratio:

Long Descriptor: Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve

Reference Set (y/n):

Global Period: 090

Frequency:

Impact:

Source:

Year:

Public Comment Letter: AAOS

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
27894	100	0	0	0	0	0	0	0

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
27894	.	98	.

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27894	.	100	.

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
27894	cardiovascular disease	2
	general surgery	49
	group practices	2
	orthopedic surgery	22.4
	plastic surgery	16.3
	vascular surgery	8.2

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27894								

Public Comments

05-Jul-95

AAOS	090	7.64	.	.
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27894								
AAOS	7.64	7.64	.	.	1.00	1.00	.	.

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
27894								
AAOS	090	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27894									
AAOS

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
27894									
AAOS	7.64	.	.	.	.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 27259 Global Period: 090 Current RVW: 18.03 Recommended RVW: 20.50

CPT Descriptor:

Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening

Source and Summary of Comment to HCFA on this service: AAP recommended an RVW of 24. The rationale was as follows: This code is not used in adults. Relative work is similar to 35646 or 21433.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4 year old female with developmental dislocation of the hip undergoes open reduction of the hip and femoral shortening osteotomy.

Description of Pre-Service Work: Pre-service work provided from the day before surgery until the time of the procedure includes: the hospital admission work-up, as well as evaluation of initially obtained information including x-ray studies. Although the pre-operative decision processes occurred prior to the day before surgery, all of these records are reviewed and the parents of the patient are once again counseled in regards to the procedure, the risks, and implications as well as to the necessary post-operative course. This often occurs on the morning of surgery with same day admission. Current history and physical is taken to make sure that in addition to the orthopaedic history and physical, a brief general history and physical is taken to make sure that the child is not sick and that there are no contrary indications to the anesthesia and procedure. The patient is then brought to the operating room, and after induction of anesthesia, is carefully positioned in a manner to allow the hip to be approached and appropriate x-rays to be obtained. This procedure is always done with some type of radiographic monitoring, often with a c-arm. Checking the position of the patient to make sure that adequate radiographic control will occur during surgery is next performed. Appropriate draping of the patient to allow the hip area to be exposed is performed, followed by surgical preparation of the patient and scrubbing of the physician. The patient is draped to allow adequate exposure of the hip and mobilization of the extremity as is necessary. It should be noted that in the pediatric population, assistance with induction of anesthesia and placement of appropriate intravenous lines is often performed in conjunction with the anesthesiologist in the operating room.

Description of Intra-Service Work: Intra-service work involves the placement of usually two skin incisions, the first of which is along the iliac crest and exposes the anterior hip joint. This incision involves mobilization of the abductor musculature from the ileum, rectus femorous musculature from the pelvis, as well as sartorius musculature from the pelvis. The entire hip capsule is exposed anteriorly and opened in an appropriate manner to allow reduction of the hip. The acetabulum is cleaned of the ligamentum teres and the fat gland that may be present. The reduction of the hip is deferred until the femoral shaft osteotomy is performed. The surgeon may elect to extend the incision over the entire anterior leg extending laterally or to make a second incision over the greater trochanter and extending distally for 4 to 5 inches to expose the subtrochanteric area of the femur. This is exposed circumferentially after elevating the vastus lateralis and vastus intermedius muscle and dividing the tensor fasciae latae longitudinally. The femoral osteotomy is then performed to allow the femur to be shortened to take pressure off of the hip. At this point, the hip is then reduced and the reduction is checked for stability. At the appropriate femoral shaft length, the femur is cut and the proximal femur is then attached to the distal femur with some type of screw plate device often with a preliminary placement of guide pins in the femoral neck. This fixation is completed. The hip is then reduced and a capsulorrhaphy is performed in order to maintain the reduction. The wound is then closed. The closure involves approximation of all the muscles that have been divided from their origins including sartorius, rectus femorous, gluteus medius, and tensor fasciae latae. Through the lateral incision, the vastus lateralis and intermedius are re-attached and the tensor fasciae latae is approximated. Stability of the hip is checked under c-arm control prior to closure. The wounds are sterilely dressed.

CPT Code: 27259

Description of Post-Service Work: After completion of the surgical work, the patient is placed on a casting frame and x-ray verification of the position of the hip on the casting frame is often obtained. Bilateral spica cast is then applied. This involves placement of appropriate protective felt pads and the positioning of the hip that is more satisfactory for maintenance of the reduction and stabilization of the hip. The cast goes from the nipple line, usually to the toes of both feet. Following application of this cast, careful trimming of the cast to allow hygiene as well as urinary and perineal care is performed. An x-ray is taken in the cast to make sure the position of the hip is adequate. If necessary a post-operative CT scan of the hip is obtained to verify the position interpretation of these x-rays and interpretation of the CT scan if taken is necessary for follow-up care. The patient is then awakened. Care is taken to make sure there is adequate room in the cast for expansion of the abdomen during eating and breathing. Following awakening from anesthesia, and satisfactory of the patient, the operative note is dictated, and orders are written. Following this the surgeon will then counsel the family in regards to the procedure that has been performed, the expectations, and follow-up care.

The patient is subsequently seen on the day of surgery in follow-up to make sure that the distal extremity function is appropriate and there is appropriate room for the abdomen and additional trimming of the cast if necessary. The patient is then hospitalized for 4 days post-operatively, the patient being visited once or twice by the attending physician to make sure that function is adequate. Instruction of the parents and caregivers in regards to care of the patient including care of the cast is performed. Communication with the patient's primary care physician occurs usually on the day of surgery. Following discharge from the hospital, the patient is seen in approximately one week to make sure he is doing well in the cast with trimming as necessary and an x-ray being taken in the cast to make sure that the position is adequate. The patient is then seen in follow-up in 3 to 4 weeks after the initial follow-up visit with new x-rays being obtained, the patient is carefully examined, and the cast modified as necessary. At approximately 6 to 8 weeks after surgery, the patient is again seen in follow-up and the cast is either removed in the office and a new cast applied or the patient is scheduled for surgery for purposes of examination under anesthesia and placement of a new spica cast. This procedure is performed under anesthesia in the very young children where change of the cast in the office is not reasonable. The patient is then seen approximately one month after this cast change and seen monthly there after. Each visit consists of examination, x-rays, interpretation of the x-rays, and modification of the cast as necessary. At approximately 90 days post-operatively, the patient is removed from the spica cast and begun mobilization of the hips. This visit includes arrangements for any necessary physical therapy and gait instructions, evaluation of the extremities in regards to mobilization of the extremities, and arrangement of the necessary post-operative post-casting course at home. An average of four post-surgery office visits are performed.

SURVEY DATA:

Specialty: American Academy of Pediatrics

Sample Size: 103 Response Rate (%): 30% Median RVW: 20.50

25th Percentile RVW: 19.45 75th Percentile RVW: 25.00 Low: 19.45 High: 35.00

Median Pre-Service Time: 90 min Median Intra-Service Time: 210 min

25th Percentile Intra-Svc Time: 180 min 75th Percentile Intra-Svc Time: 240 m Low: 150 m High: 390 m

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30 min</u>	
ICU:	<u>0 min</u>	<u>0</u>
Other Hospital:	<u>60 min</u>	<u>4</u>
Office:	<u>70 min</u>	<u>4</u>

CPT Code: 27259**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft	18.68
2)	27165*	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast	16.20
3)	27254	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation	17.29

*indicates presence on MPC

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

27259 involves 3.5 times more intra-service work than 27165, 1.75 times more than 27130, and 1.4 times more than 27254. Mental effort and judgement are higher for 27259 than the 3 referenced codes. Technical skill and effort are equal for 27259, both are more than the other reference codes. Psychological stress is the highest for 27259. Similar work is present for 27259 and 27130 pre-operative positioning and evaluation. However, significantly less consultation is necessary for 27130 as one is only dealing with the patient and not the entire family. This code does not involve the risks of growth of the hip that are present with 27259. The surgical procedure 27130 involves a similar but significantly less extensive surgical exposure of the hip joint and capsule and similar opening of the capsule. 27130 does not involve the femoral osteotomy and does not involve reduction of the hip into the acetabulum and capsulorrhaphy. 27130 does involve the prosthetic replacement of the proximal femur of acetabulum. Post-service period of 27130 does not involve application of the spica cast. It involves significantly less office visits and slightly more post-surgery hospitalization time.

27165 is identical to the femoral osteotomy portion of 27259 and could be used in conjunction with 27258 for separate coding of this procedure when done in separate operations.

27254 involves similar but less extensive acetabular exposure. It does involve fixation of the fracture fragments rather than the repair of the capsule and reduction of the hip.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Review of the survey results indicates the mean intra-operative time for 27259 is 3.5 times longer than for 27165, 1.75 times longer than 27130, and 1.4 times longer than 27254. The median surveyed intra-service time of 210 minutes is significantly greater than the 141 minutes suggested by the Harvard data. Thus, the Academy is recommending that the RVW be increased from 18.03 to 20.50.

Public Comments

30-Jun-95

Code: 27259 **1995 RVUs:** 18.03 **Recommended RVUs:** 24.00 **Ratio:**

Long Descriptor: Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological); replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 2 **Impact:** 12

Source: 1 **Year:** 92 **Public Comment Letter:** 347

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS, AAP

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
27259	4	2	-29.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
27259	75	100	12.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
27259	orthopedic surgery	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
27259							
	AAP	090	090	16.49	18.03	1.09	18.03

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
27259								
AAP	18.03	18.03	1.09	1.00	1.00	1.00	24.00	347

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
27259								
AAP	090	16.49		29	*	141		50

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
27259									
AAP	*	1.0		10	7.5	*	10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
27259									
AAP	*	10		24.00	18.03	or	3		0.071

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 27725 Global Period: 090 Current RVW: 11.04 Recommended RVW: 14.50

CPT Descriptor:

Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method

Source and Summary of Comment to HCFA on this service: AAOS recommended an RVW of 16.10 based on the Abt Study. The AAOS decided not to survey this code.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10 year old male with non-union of the tibia undergoes transport of ipsilateral fibula and creation of proximal and distal synostosis, not including bone graft.

Description of Pre-Service Work: Pre-service work includes the admission evaluation including an updated history and physical to make sure that the patient is not ill as well as the evaluation of any changes that have occurred in the lower extremities since the time of the last office visit. Repeat counseling of the patient and the family will occur with an elaborate discussion of the risks and expectations. In the operating room, proper position of the patient must occur after induction of anesthesia to allow for appropriate x-rays to be taken on an intra-operative basis. Often the c-arm may be utilized. Positioning and testing of the c-arm is necessary. The tourniquet is then placed by the operating physician and proper preparation of the iliac crest donor site that may be used is also made. This procedure may be done in the lateral or prone position. Positioning involved in the prone and lateral position is significant to make sure that adequate positioning and avoidance of any skin pressure present as well as avoidance of any pressure on the opposite perineal nerve. The leg and the potential donor site are then prepped, usually by the operating room staff while the surgeon scrubs. After gowning and gloving, the surgeon drapes the wound to allow appropriate exposure. The extremity is then exsanguinated and the tourniquet elevated to a reasonable pressure to allow a relatively bloodless field for the surgical procedure.

Description of Intra-Service Work: This procedure is often done for an open unhealed tibia fracture. Exposure is usually made over the fibula and carried down carefully avoiding any damage to the perineal nerve, posterior tibial artery, or posterior tibial nerve. Exposure is carried down just posterior to the interosseous membrane to the level of the previous tibia fracture. Incision needs to be almost 80% of the length of the fibula to allow transport of the fibula to the tibia. After appropriate preparation of the tibial beds for transport, appropriate osteotomies are made on the proximal and distal fibula. The fibula is mobilized on its neurovascular bundle usually without dissection of the neurovascular bundle, to level of the tibia where it is approximated often with screws from the fibula to the tibia. Careful x-ray control to make sure that the alignment on the tibia is appropriate as the fibula is fixed to the tibia proximally and distally is made. Additional bone grafting is often used in this posterior bed. This is often obtained from the iliac crest with a separate incision. Careful evaluation of the blood supply is made. The tourniquet is deflated prior to any closure. The ankle is addressed and after the fibular osteotomy, it is often necessary to stabilize the remaining distal fibula to the tibia. This is usually done with 1 or 2 syndesmosis screws that are done under x-ray control from the fibula to the tibia. It is usually not necessary to stabilize the proximal fibula. The wound is then closed in layers over drains in an appropriate manner and the patient is immobilized in a splint or cast post-operatively. Vascular evaluation after the transfer is performed.

CPT Code: 27725

Description of Post-Service Work: After completion of the wound closure, a cast or splint is applied and the wound is dressed as the patient awakens in the recovery area. Evaluation of the neurological function after the patient is awakened occurs as well as any drainage, orders are written. Operative note is dictated and the family of the patient is counseled at length in regards to what has occurred. Post-operative x-rays are usually taken and evaluated in the recovery room. This is in addition to the intra-operative films. The patient is seen later that day and evaluated in regards to the neurovascular function and swelling. Post-operative visits in the hospital occur with evaluation of the lower extremity in regards to neurovascular function and swelling. Post-operative visits in the hospital occur with evaluation of the lower extremity in regards to neurological function, vascular supply, and swelling. If a patient has been placed in a splint, this may be changed to a cast prior to discharge. If a cast has been applied, it may be necessary to split the cast to allow for adequate circulation to occur. The patient is seen during the first 90 days post-operatively approximately four times. The patient is usually discharged on the fourth post-operative day. These visits include evaluation of the wound, x-rays that are taken at approximately one month, and at two months and at three months. If a shunt has been used in the hospital, casts are usually applied on the first post-discharge visit. This will be changed on a monthly basis in the office with removal of the cast. Evaluation of the wounds and application of a new cast will be done in the office. Post-discharge visits usually occur approximately one week following discharge, one month following surgery, two months following surgery, and three months following surgery.

SURVEY DATA:Specialty: American Academy of PediatricsSample Size: 103 Response Rate (%): 30% Median RVW: 14.5025th Percentile RVW: 12.00 75th Percentile RVW: 16.13 Low: 12.00 High: 45.00Median Pre-Service Time: 60 min Median Intra-Service Time: 150 min25th Percentile Intra-Svc Time: 120 min 75th Percentile Intra-Svc Time: 180 m Low: 90 m High: 240 m

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30 min</u>	
ICU:	<u>0 min</u>	<u>0</u>
Other Hospital:	<u>60 min</u>	<u>4</u>
Office:	<u>80 min</u>	<u>4</u>

CPT Code: 27725**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	27758	Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage	10.51
2)	24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	14.28

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

27758 involves significantly less pre-operative evaluation and counseling. The intra-operative procedure is a much more limited exposure with application of the fixation device. Osteotomy and transport of the fibula and fixation of the fibula is not necessary. The wound is much less involved than the wound in 27725. Position is necessary, but does not need to be as exact as with 27725.

24410 involves an exposure of similar difficulty with multiple osteotomies of the humerus and intramedullary rodding done under x-ray control. The level of difficulty of this surgical procedure is identical. The wound exposure is of equal significance in difficulty.

However, 27725 usually involves a much more complex situation with missing bone from the tibia being present. The overall level of difficulty of 24410 is very similar to 27725. Mental effort, judgment, technical skill, physical effort and psychological stress is dramatically lower for 27725 than 27758. The se factors are more for 27725 than 24410. 24410 demands more mental effort, technical skill, and psychological stress than 27758.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

27725 demands extensive technical skill and physical effort for the exposure and transport of the fibula to the tibia. This is often done with a dramatic defect in the tibia being present. AN increased time and physical effort is well documented by the median surveyed intra-operative times which are 2.5 times that of 27758 and 167% of 27514. In addition, the median surveyed intra-operative time of 150 minutes is significantly greater than the 121 minutes suggested by the Harvard data. Thus, the Academy is recommending an increase in the RVW from 11.04 to 14.50.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 28760 Global Period: 090 Current RVW: 5.47 Recommended RVW: 8.00

CPT Descriptor: Arthrodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure)

Source and Summary of Comment to HCFA on this service: AAP recommended an RVW of 9.82. The rationale was as follows: This code is undervalued. Relative work is similar to 27418. Complexity is similar in children and adults. This procedure is commonly done in children and less commonly done in adults.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14 year old female with cavus foot and claw toes undergoes transfer of the extensor hallucis longus tendon to the first metatarsal neck and arthrodesis of the great toe interphalangeal joint.

Description of Pre-Service Work: Pre-service work includes history and physical evaluation making sure that the patient being brought to surgery is not sick or developed any interim problems. Repeat evaluation of the foot just prior to surgery in the pre-anesthesia area or in the ward is performed to verify the indications and recommendations. This includes re-evaluation of all the x-rays that are available. Repeat counseling of the patient and family is performed with verification of the operative permission being obtained. The patient is brought to the operating room and anesthesia is inducted. The surgeon then positions the patient in a manner to allow exposure of the foot for the surgical procedure. X-ray control is often utilized for the arthrodesis portion of the great toe. Positioning the patient to allow adequate x-ray exposure is mandatory. Elevation of the pelvis to rotate the leg in an appropriate manner is necessary. The tourniquet is placed by the operating surgeon. The lower extremity is then prepped by the operating staff while the surgeon scrubs. After the surgeon is dressed, the lower extremity is draped and the tourniquet elevated to an appropriate pressure.

Description of Intra-Service Work: Intra-service work involves the planning of an appropriate incision to allow exposure and transfer of the extensor hallucis longus tendon, as well as exposure of the interphalangeal joint. Usually a fixation device is placed through the distal portion of the distal phalanx. Surgical exposure involves exposure of the extensor tendon, both at the IP joint level and the dorsal foot. Care to avoid division of the short extensor tendons and sensory nerves is made and the extensors hallucis longus tendon is brought proximal. It is necessary to expose the neck of the first metatarsal so that an appropriate hole can be made to transfer the extensor hallucis longus tendon through the metatarsal neck in the dorsiflexed position. After this has been passed through the appropriately prepared holes, it is sutured upon itself so that it may function as a dorsiflexor of the first metatarsal. Following this, the IP joint of the first toe is prepared for fusion by removing the cartilage from the distal proximal phalanx, making sure that these are prepared in a manner to place the toe in an ideal position. The joint is then reduced to the desired position and fixed with either longitudinal Steinmann pin, Kirschner wire or threaded screw. X-ray control is often obtained to make sure that the placement has been in the most desired position. The position of the foot is then evaluated, the wound irrigated and closed usually after release of the tourniquet. A sterile dressing is applied.

Description of Post-Service Work: Post-service work includes application of a splint with the ankle dorsiflexed at 90 degrees with the foot in the desired position or a short leg cast that will allow the patient to walk. After the patient is awakened and returned to the recovery room, circulation of the foot is evaluated. Post-operative orders are written and the operative note is dictated. The family then is counseled in regards to the procedure and plan. Later on the same surgical day, the patient is seen in follow-up to make sure that circulation is maintained. Post-operatively the patient is hospitalized for an average of 2 days with the necessity of a cast or splint being changed to a short-leg walking cast. As soon as the patient is comfortable and circulation is adequate, the patient is discharged to office follow-up, where an average of four visits are necessary within the first 90 days. The first visit usually takes place one week after surgery and the wound is inspected and the cast may be changed. The patient is seen one month, two months, and three months following surgery. Usually at a period of three months, the cast is discontinued and the patient allowed to ambulate. If a brace was necessary prior to surgery, the brace is refitted or refabricated as necessary.

CPT Code: 28760**SURVEY DATA:**Specialty: American Academy of PediatricsSample Size: 103 Response Rate (%): 30% Median RVW: 8.0025th Percentile RVW: 6.50 75th Percentile RVW: 9.80 Low: 5.00 High: 12.00Median Pre-Service Time: 60 min Median Intra-Service Time: 90 min25th Percentile Intra-Svc Time: 62.5 min 75th Percentile Intra-Svc Time: 102.5 m Low: 60 m High: 150 mMedian Post-Service Time: Total Time Number of Visits

Day of Procedure:	<u>30 min</u>	
ICU:	<u>0 min</u>	<u>0</u>
Other Hospital:	<u>27.5 min</u>	<u>2</u>
Office:	<u>60 min</u>	<u>4</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	28285*	Hammertoe operation, one toe (eg, interphalangeal fusion, filleting, phalangectomy)	4.41
2)	28485*	Open treatment of metatarsal fracture, with or without internal or external fixation, each	5.31
3)	28725	Subtalar arthrodesis	10.86
4)	28264	Capsulotomy, midtarsal (Heyman type procedure)	9.80

*indicates presence on MPC

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Pre-operative time and intensity is significantly more for 28760 than for 28285 and is equal to 28485 and 28725. 28760 is significantly more physician work than 28285 and 28485. The physician work of 28760 is similar to that of 28725 and 28264.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Intra-operative time for 28760 are significantly more than for 28285 (6 times more) and 28485 (2 times more), and more similar to 28725 (86%) and 28264 (116 percent). Mental effort and judgment are identical for 28760, 28725, and 28264, and significantly higher than for 28285 and 28485. Technical skill and physical effort have a similar between 28760 and the reference services. Psychological stress is related in a similar manner. Also, the median surveyed intra-service time of 90 minutes is significantly greater than the 63 minutes suggested by Harvard data. Thus, the Academy is recommending an increase in the RVW from 5.47 to 8.00.

Public Comments

30-Jun-95

Code: 28760

1995 RVUs: 5.47

Recommended RVUs: 9.82

Ratio:

Long Descriptor: Arthrodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure)

Reference Set (y/n): N

Global Period: 090

Frequency: 410

Impact: 1784

Source: 1

Year: 92

Public Comment Letter: 347

Reference Services:

CMD Comment:

--

Societies Wishing to Survey: AAOS, AAP

Societies Wishing to Comment: APMA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
28760	26.7	6.7	6.7	60	26.7	0	0	7.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28760	484	428	-6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28760	31	18.2	-6.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28760	group practices	5.1
	orthopedic surgery	42.5
	podiatry	50.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
28760	138	1.7	LATE EFFECTS OF ACUTE POLIOMYELIT
	173	1.7	OTHER MALIGNANT NEOPLASM OF SKIN
	356	1.7	HEREDITARY AND IDIOPATHIC PERIPHE

Public Comments

30-Jun-95

707	1.7	CHRONIC ULCER OF SKIN
715	5	OSTEOARTHRISIS AND ALLIED DISORD
726	3.3	PERIPHERAL ENTHESOPATHIES AND AL
735	18.3	ACQUIRED DEFORMITIES OF TOE
736	8.3	OTHER ACQUIRED DEFORMITIES OF LIM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28760							
AAP		090	090	5.38	5.47	1.02	5.47

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28760								
AAP	5.47	5.47	1.02	1.00	1.00	1.00	9.82	347

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
28760								
AAP	090	5.38		21	*	63		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
28760									
AAP	*	0.5	*	10	1.0	*	10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
28760									
AAP	*	10		9.82	5.47	or	3		0.040

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Podiatry

The American Podiatric Medical Association, Inc. (APMA) submitted comments to HCFA on services that their members frequently perform which may be inappropriately valued. Their comments were based on surveys of the members of the organization representing the spectrum of foot and ankle services as well as geographic diversity. In addition, the organization also relied on data from two previous national surveys on pre-service and intra-service care prepared by the APMA for the Physician Payment Review Commission.

APMA submitted recommendations to the RUC for review in two formats: 1) surveyed services with completed summary of recommendation forms; and 2) a letter detailing rationale for those services they did not survey. The RUC did not believe the APMA had provided compelling evidence for changing the RVUs for any of the services for which no survey was conducted.

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
28080	Removal of foot lesion	3.18	3.18	The work is similar to code 64774 <i>Excision of neuroma; cutaneous nerve, surgically identifiable</i> (work RVU = 4.86). The intraservice time of 28080 is greater as the physician is required to excise a "deep" neuroma. The intensity of the two services are the same.	The APMA survey time was equal to the Harvard survey. No other compelling evidence was presented.	2

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
28113	Part removal of metatarsal	4.09	4.23	<p>The work is similar to code 28112 <i>Ostectomy, complete excision; other metatarsal head (second, third, or fourth)</i> (rvw = 4.23). The work to perform an ostectomy of the fifth metatarsal is virtually the same, measured in time and intensity. In fact, the postoperative management of 28113 is frequently more complicated and often involves longer healing time and greater patient disability due to the lateral shoe pressure of the operative site.</p> <p>The AAOS commented that they agreed with this recommendation.</p>	The RUC agreed that the work RVU for 28113 should be equal to 28112.	4

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
28114	Removal of metatarsal heads	7.16	7.16	<p>This service is comparable to 28112 [RVW 4.23] billed three times and 28113 [4.09]. The multiple surgery rule would equal 10.51 (100% of 4.23, 50% of 4.23, 50% of 4.23, and 50% of 4.09). In addition, the new RVW of 10.51 would still not recognize the additional work associated with performing the partial phalangectomies at each metatarsophalangeal joint.</p> <p>AAOS agrees with recommendation and compares the work of this service to 28725 <i>subtalar arthrodesis</i> (work RVU = 10.86).</p>	No compelling evidence was presented to increase the current value. APMA will have the opportunity to present further evidence in February	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
28120	Part removal of ankle/heel	4.81	4.81	This service is more work than 28122 <i>Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis or tarsal bossing), talus or metatarsal bone, (work RVU = 6.62).</i>	APMA did not perform a survey for this code. No other compelling evidence was presented.	2
28190	Removal of foot foreign body	1.91	1.91	An individual commented that this service is overvalued compared to 10120 <i>Incision and removal of foreign body, subcutaneous tissues; simple (RVU = 1.19).</i>	No presentation was made on this code. The RUC recommends that the rank order between codes 28190 and 10120 is currently correct.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
28200	Repair of foot tendon	4.45	4.45	<p>In the public comment process, APMA presented HCFA with a list of potential overvalued codes. The APMA supplied no additional rationale for these recommendations and stated that "the information used to reach our conclusions was not as detailed or precise as the data used to support the revaluation of "undervalued" procedures.</p> <p>The AAOS submitted a letter to the RUC requesting that these values remain the same and indicated the following reasons:</p> <p>*services have not been included in any previous refinement processes.</p> <p>*services do not meet the criteria used by the RUC and Dan Dunn to select overvalued services.</p> <p>*alteration in the rank order relationships between paired codes will occur if the APMA recommendations are adopted</p> <p>*relationship of current IWPUT with other similar codes are equal</p>	The RUC agrees with the points made by the AAOS and recommends that the current values be retained.	2
28202	Repair/graft of foot tendon	6.38	6.38			2
28208	Repair of foot tendon	4.11	4.11			2
28220	Release of foot tendon	4.27	4.27			2
28222	Release of foot tendons	5.36	5.36			2
28225	Release of foot tendon	3.42	3.42			2
28226	Release of foot tendons	4.27	4.27			2
28230	Incision of foot tendon(s)	4.00	4.00			2
28232	Incision of toe tendon	3.26	3.26			2
28234	Incision of foot tendon	3.19	3.19			2
28270	Release of foot contracture	4.58	4.58			2
28272	Release of toe joint, each	3.67	3.67			2
28341	Resect enlarged toe	7.86	7.86			2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
28285	Repair of hammertoe	4.41	4.41	The American Society of General Surgeons included this service in a list of codes submitted in their public comment letter. The ASGS comments were based on a study using the whipple procedure as a benchmark.	No survey data or other compelling evidence was presented for this service.	2
28288	Partial removal of foot bone	3.73	4.23	APMA commented that this service is comparable to 28285 <i>Repair of a hammertoe</i> (rvu = 4.41). These services require almost the same amount of pre- and intra-service work. The intensity and mental judgment and effort are essentially the same for both procedures	RUC evaluated the APMA survey and an AAOS comment and agreed that the work is similar to 28122 <i>Ostectomy, complete excision; metatarsal head (second, third, or fourth)</i> (RVU = 4.23). This procedure is typically performed on the 5th metatarsal and there is an increase in post-operative complications.	4

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
28292	Correction of bunion	6.24	6.24	These services are undervalued when compared to reference services 28296 <i>Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchel, Chevron, or concentric type procedures)</i> (work RVU = 8.69)	The APMA survey intra-service time is equal to Harvard data. No other compelling evidence was presented.	2
28293	Correction of bunion	8.25	8.25			2
28299	Correction of bunion	8.46	8.46		APMA did not conduct a survey for this service. No other compelling evidence was presented.	2
28755	Fusion of big toe joint	4.48	4.48	APMA presented a letter recommending that this service be greater than code 28285 <i>Hammertoe operation, one toe (eg, interphalangeal fusion, filleting, phalngectomy)</i> (work RVU = 4.41) because there is an increased amount of intraservice and postservice work. The intensity for this service is also greater than 28285.	APMA did not conduct a survey for this service. No other compelling evidence was presented.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
28238	Revision of foot tendon	7.27	7.27	This service is similar to 28296 <i>Hallux galgus (bonion) correction with metatarsal osteotomy</i> (rvu = 8.69).	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
28344	Repair extra toe(s)	3.89	3.89	This service is more work than 28285 <i>Repair of hammertoe</i> (rvu = 4.41).		2
28476	Repair metatarsal fracture	3.15	3.15	This service is similar to 26608 <i>Percutaneous skeletal fixation of metacarpal fracture, each bone</i> (rvu = 5.12).		2
28496	Repair big toe fracture	2.18	2.18	This service is similar to 26608 <i>Percutaneous skeletal fixation of metacarpal fracture, each bone</i> (rvu = 5.12). APMA recommends that the RVU for this service should be more than 28496.		2

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
28531	Treat sesamoid bone fracture	2.01	2.01	This service is more work than 28525 <i>Open treatment of fracture, phalanx or phalanges, other than great toe, with or without internal or external fixation</i> (rvu = 3.08). This services involves working in an anatomical area that is less accessible than any phalanx.	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
28576	Treat foot dislocation	3.75	3.75	This service is similar to 26676 <i>Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb (Bennett fracture), single, with manipulation</i> (rvu = 5.29).		2

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
28636	Treat toe dislocation	2.67	2.67	This service is identical to 26706 <i>Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation</i> (rvu = 4.92). The risks associated with performing this service may be greater than 28636 because of the increased postoperative hazards with performing a procedure on a weightbearing structure like the foot.	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
28666	Treat toe dislocation	2.56	2.56	This service is identical to 26776 <i>Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation</i> (rvu = 4.60).		2

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
M0101	Cutting or removal of corns	0.37	0.45	This service is more work than 11050 <i>Paring or curettement of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae) not extending through the stratum corneum (eg, callus or wart) with or without local anesthesia; single lesion</i> (work RVU = .43). The technical skill for these services are similar, however physician physical effort is much greater for M0101. M0101 involves treating more than two skin lesions and trimming ten toenails.	M1010 was assigned a work RVU by HCFA. The APMA had no input and was not included in the Harvard study. Medicare has specific coverage guidelines for this service. The patients typically have poor circulation, and neurological deficit concomitant to systemic disease. Considering the patient population that receives this service, the RUC agreed that this code is undervalued. The work RVU should be higher than 11050.	4

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 28113 Global Period: 090 Current RVW: 4.09

Recommended RVW: 4.50

CPT Descriptor: Ostectomy, complete excision; fifth metatarsal head

Source and Summary of Comment to HCFA on this service:

American Podiatric Medical Association

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57 year-old female undergoes the complete resection of the fifth metatarsal head in a hospital outpatient surgery department.

Description of Pre-Service Work:

Review of chart with general medical history update including current medications and allergies. Physical examination includes evaluating the neurological and vascular status of the patient. Laboratory tests and roentgenograms are ordered and reviewed prior to surgery. The operative risks and benefits are discussed with the patient and informed consent is obtained. Pre-service work also includes pre-operative scrubbing, positioning, exsanguinating and draping the patient's extremity.

Description of Intra-Service Work:

A 3.5 cm. dorsolateral skin incision is made over the distal one third of the fifth metatarsal bone. The incision is deepened with a combination of sharp and blunt dissection to expose the fifth metatarsophalangeal joint capsule. Care is taken to protect all neurovascular structures. A linear capsulotomy is performed. The capsule and periosteum are underscored exposing the head of the fifth metatarsal. An osteotomy is performed perpendicular to the long axis of the fifth metatarsal at the surgical neck. The head of the metatarsal is removed by sharp dissection. Abrupt or rough edges of the metatarsal neck are rasped smooth. The capsule and periosteum are reapproximated with appropriate suture material. The fifth metatarsophalangeal joint capsule is hour-glassed using appropriate suture material. The superficial fascia and subcutaneous tissue are coapted and maintained with simple interrupted sutures. The skin is closed with an absorbable subcuticular suture. An appropriate amount of soluble steroid is injected into the surgical site. The foot is cleansed and dried, and Steri-strips are applied perpendicular to the incision line. A dry sterile dressing and compression wrap are applied to the foot.

Description of Post-Service Work:

The patient's vital signs and neurovascular status are evaluated and stabilized. Post-operative roentgenograms are ordered and reviewed. The medical record is completed, including postoperative orders. The operative report and discharge summary are dictated. Written homecare instructions are given and explained to the patient. Appropriate prescriptions are written, given and explained to the patient. The patient is seen five times in the office during the 90 day global period for dressing changes, suture removal and rehabilitation.

SURVEY DATA:

Specialty: Podiatric Medicine

Sample Size: 74 Response Rate (%): 85.1 Median RVW: 4.50

25th Percentile RVW: 4.0 75th Percentile RVW: 5.10

Low: 3.20 High: 7.16

Median Pre-Service Time: 20 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 45

Low: 10 High: 120

Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	20	
ICU:	NA	NA
Other Hospital:	NA	NA
Office:	70	5

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	RVW
1)	28112	Ostectomy, complete excision; metatarsal head (second, third or fourth)	4.23

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre-, intra-, and post-service time and intensity reported by the survey results were virtually identical for 28113 and reference procedure 28112.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The correct RVW for 28113 should be 4.50. 4.23 is the RVW established by the fee schedule for reference procedure 28112 [Ostectomy, complete excision; other metatarsal head (second, third or fourth)]. It takes virtually the same amount work, measured in time and intensity, to perform an ostectomy (complete excision) of any lesser metatarsal head, including the fifth metatarsal. In fact, the postoperative management of a 28113 is frequently more complicated and often involves longer healing time and greater patient disability due to the lateral shoe pressure on the operative site.

Public Comments

30-Jun-95

Code: 28113

1995 RVUs: 4.09

Recommended RVUs: 4.23

Ratio:

Long Descriptor: Osteotomy, complete excision; fifth metatarsal head

Reference Set (y/n): N

Global Period: 090

Frequency: 1,885

Impact: 264

Source: 4

Year: 93

Public Comment Letter: 216

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOS, APMA

Societies Wishing to Comment: AAP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
28113	32.7	3.6	7.3	76.4	14.5	1.8	3.6	23.5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28113	2034	2138	2.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28113	27.2	26.9	-0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28113	general surgery	3.2
	orthopedic surgery	27.8
	podiatry	65.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
28113	250	3.2	DIABETES MELLITUS
	707	3.6	CHRONIC ULCER OF SKIN
	714	3.2	RHEUMATOID ARTHRITIS AND OTHER I
	726	4.1	PERIPHERAL ENTHESOPATHIES AND AL

Public Comments

30-Jun-95

727	6.4	OTHER DISORDERS OF SYNOVIUM, TEN
730	3.6	OSTEOMYELITIS, PERIOSTITIS, AND OTH
735	7.7	ACQUIRED DEFORMITIES OF TOE
736	1.8	OTHER ACQUIRED DEFORMITIES OF LIM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28113							
APMA		090	090	4.25	4.09	0.96	4.09

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28113								
APMA	4.09	4.09	0.96	1.00	1.00	1.00	4.23	216

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
28113								
APMA	090	4.25		18	*	33		30

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
28113									
APMA	*	0.5	*	10	0.5	*	10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
28113									
APMA	*	10		4.23	4.09	or	3		0.057

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 28288 Global Period: 090 Current RVW: 3.73

Recommended RVW: 4.50

CPT Descriptor: Osteotomy, partial, exostectomy or condylectomy, single, metatarsal head, first through fifth, each metatarsal head

Source and Summary of Comment to HCFA on this service:

American Podiatric Medical Association

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year-old female undergoes a partial 5th metatarsal head resection in an office surgical suite (assumes block administered by surgeon).

Description of Pre-Service Work:

Review of chart with general medical history update including current medications and allergies. Physical examination includes evaluating the neurological and vascular status of the patient. Laboratory tests and Xrays are reviewed prior to surgery. The patient's vital signs are taken. The operative risks and benefits are discussed with the patient and an informed consent is obtained. The patient is placed in a supine position. A local anesthetic is administered. The instruments used in the procedure are removed from the sterilizer. Pre-service work also includes pre-operative scrubbing, positioning, prepping, tourniquet application, exsanguination, and draping the patient's extremity.

Description of Intra-Service Work:

A 3.5 cm dorsolateral linear skin incision is made over the distal one third of the fifth metatarsal bone. The incision is deepened with a combination of sharp and blunt dissection to expose the fifth metatarsophalangeal joint capsule. Care is taken to protect all neurovascular structures. A linear capsulotomy is performed. The capsule and periosteum are underscored exposing the head of the fifth metatarsal. The hypertrophic lateral aspect of the metatarsal head is resected and abrupt bone edges rasped smooth. The capsule and periosteum are reapproximated with appropriate suture material. The superficial fascia and subcutaneous tissue are coaptated and maintained with simple interrupted sutures. The skin is closed with an absorbable subcuticular suture. An appropriate amount of soluble steroid is injected into the surgical site. The foot is cleansed and dried, and Steri-strips are applied perpendicular to the incision line. A dry sterile dressing and compression wrap are applied to the foot.

Description of Post-Service Work:

A surgical shoe is fitted to the patient. The patient's vital signs and neurovascular status are evaluated and stabilized. Written homecare instructions are given and explained to the patient. Appropriate prescriptions are written, given and explained to the patient. The medical record is completed, including a written operative report. The patient is seen in the office five times during the 90 day global period for dressing changes, suture removal and rehabilitation.

SURVEY DATA:

Specialty: Podiatric Medicine

Sample Size: 75 Response Rate (%): 86 Median RVW: 4.50

25th Percentile RVW: 4.0 75th Percentile RVW: 5.1 Low: 2.90 High: 7.50

Median Pre-Service Time: 20 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 45

Low: 15 High: 85

Median Post-Service Time: 20 30

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	20	
ICU:	NA	NA
Other Hospital:	NA	NA
Office:	65	5

Day of Procedure:

20

ICU:

NA

NA

Other Hospital:

NA

NA

Office:

65

5

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	28112	Ostectomy, complete excision; metatarsal head (second, third or fourth)	4.23

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The survey indicated that the pre-, intra- and post-service time and intensity of 28288 was almost identical to key reference procedure 28112. The post-service time for 28288 during the 90 day global period was approximately 5% greater than 28112.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The correct RVW for 28288 should be 4.50 and not 3.73. 28288 compares very favorably with the amount of work performed by the physician doing reference procedure 28112 (RVW 4.23). 28112 requires almost the same amount of perioperative work, although the survey indicated that 28288 required slightly more post-service time and intra-service physician work. The intensity and mental judgment and effort are essentially the same for both procedures.

Public Comments

30-Jun-95

Code: 28288

1995 RVUs: 3.73

Recommended RVUs: 4.40

Ratio:

Long Descriptor: Osteotomy, partial, exostectomy or condylectomy, single, metatarsal head, first through fifth, each metatarsal head

Reference Set (y/n): N

Global Period: 090

Frequency: 4,509

Impact: 3021

Source: 1

Year: 92

Public Comment Letter: 216

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAOS, AAP, APMA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
28288	27.8	4.8	13.5	75.4	12.7	0	0	17.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
28288	5302	5030	-2.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
28288	19.1	17.7	-0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
28288	general surgery	2.5
	orthopedic surgery	42.5
	podiatry	52

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
28288	681	1.4	CELLULITIS AND ABSCESS OF FINGER A
	703	1.6	DISEASES OF NAIL
	707	1.6	CHRONIC ULCER OF SKIN

Public Comments

30-Jun-95

714	1.6	RHEUMATOID ARTHRITIS AND OTHER I
726	11.3	PERIPHERAL ENTHESOPATHIES AND AL
727	4.2	OTHER DISORDERS OF SYNOVIUM, TEN
735	10.7	ACQUIRED DEFORMITIES OF TOE
838	1.4	DISLOCATION OF FOOT

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
28288							
APMA		090	090	3.66	3.73	1.02	3.73

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
28288								
APMA	3.73	3.73	1.02	1.00	1.00	1.00	4.40	216

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
28288								
APMA	090	3.66		16	*	30		30

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
28288									
APMA	*	0.0	*	0	0.5	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
28288									
APMA	*	10		4.40	3.73	or	3		0.052

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT* Code: M0101 Global Period: XXX Current RVW: 0.37

Recommended RVW: 0.70

CPT* Descriptor: Cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventive maintenance care (excludes debridement of nail(s))

*HCPCS Code

Source and Summary of Comment to HCFA on this service:

American Podiatric Medical Association

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 74 year-old diabetic female with diminished pedal circulation, including absent dorsalis pedis pulses and cold feet, as well as thin shiny skin and thickened toenails has corns removed (pared) from the dorsum of the 2nd and 5th toes right foot, and 3rd and 5th toes left foot, each toe is padded with 1/8 inch adhesive felt U pad. Also, diffuse calluses are removed from the plantar aspect of both feet and adhesive moleskin pads are applied. All thickened toenails are trimmed.

Description of Pre-Service Work:

Review of office chart with general medical history update including current medications and last appointment with primary care physician. Physical examination includes evaluating the neurological and vascular status of the patient, along with a dermatologic examination. The patient's vital signs are taken. The procedural work is explained to the patient. The instruments used in treatment are removed from the sterilizer. The feet are cleansed and a skin softener is applied.

Description of Intra-Service Work:

All corns and calluses are debrided (pared) and thickened elongated toenails are trimmed. Accommodative pads are fabricated from 1/8 inch adhesive felt and moleskin and applied to the appropriate areas. Rough skin and nail edges are mechanically reduced. Antiseptic solution is applied to all nails. Skin cream is applied to both feet.

Description of Post-Service Work:

The doctor discusses future management and follow-up as necessary. The patient is advised on proper shoe gear and on diabetic foot care. The medical record is completed. Also, a note to the primary care physician is dictated as to the course and outcome of treatment and future management. (See Medicare Coverage Guidelines)

SURVEY DATA:

Specialty: Podiatric Medicine

Sample Size: 83 Response Rate (%): 95.4 Median RVW: 0.70

25th Percentile RVW: 0.54 75th Percentile RVW: 1.0 Low: 0.32 High: 4.0

Median Pre-Service Time: 5 Median Intra-Service Time: 15

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 20

Low: 3 High: 90

<u>Pre-Service Time:</u>	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	4	
ICU:	NA	NA
Other Hospital:	NA	NA
Office:	NA	NA

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	11050	Paring or curettement of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (eg, callus or wart) with or without local anesthesia; single lesion	0.43
2)	11700	Debridement of nails, manual; five or less	0.32

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Surveys indicated that the pre-, intra-, and post-service time and the intensity of M0101 were all greater than each of the key reference procedures, 11050 and 11700. The M0101 pre- and post-service times were 10-20% greater than the key reference procedures, but the intra-service time of M0101 was slightly more than two and a half times greater than 11050 and 11700.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The correct RVW for M0101 should be 0.70 and not 0.37. The physician work associated with M0101 is significantly greater than the 0.43 RVW of reference procedure 11050 (paring or curettement of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (eg callus or wart) with or without local anesthesia; single) and procedure 11700 (debridement of nails, manual; five or less). The pre-service work is slightly greater than reference procedures 11050 and 11700, but the intra-service work was reported by the survey as 250% greater than either reference procedure. When M0101 is used the physician is generally treating more than two skin lesions and trimming ten toenails. In addition, the physician also provides counseling and advice to patients receiving this kind of care.

The mental effort and judgment as well as the stress to the physician are much greater than 11050 and 11700. M0101 is typically performed on patients with poor circulation, and neurological deficit concomitant to systemic disease. Technical skill is about the same as 11050, but the physician's physical effort is much greater for M0101.

Public Comments06-Jul-95

Code: M0101**1995 RVUs:** 0.37**Recommended RVUs:** 0.56**Ratio:****Long Descriptor:****Reference Set (y/n):** N **Global Period:** XXX **Frequency:** 1,495,886 **Impact:** 284218**Source:** 2 **Year:** 92 **Public Comment Letter:** 216**Reference Services:****CMD Comment:**

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Societies Wishing to Survey: APMA**Societies Wishing to Comment:****Trends Analysis -- Beneficiary Information:**

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
M0101	73.6	33.9	8.8	70.9	3.8	0.1	0.7	5.4

Trends Analysis -- Frequency:**Trends Analysis -- Site of Service:****Trends Analysis -- Specialty Mix:****Claims-Level Diagnosis Information:**

	ICD9	Pct of Time Used	ICD9 Descriptor
M0101			
	110	4.9	DERMATOPHYTOSIS
	250	8.5	DIABETES MELLITUS
	440	8.6	ATHEROSCLEROSIS
	443	4.9	OTHER PERIPHERAL VASCULAR DISEASE
	700	1.4	CORNS AND CALLOSITIES
	701	1.3	OTHER HYPERTROPHIC AND ATROPHIC CONDITIONS OF SKIN

Public Comments06-Jul-95

703	8.8	DISEASES OF NAIL
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
M0101							
APMA			XXX	.	0.37	.	.

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
M0101								
APMA	0.56	216

Harvard Data:**Harvard Data:****Harvard Data:**

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Otolaryngology and Maxillofacial Surgery

The American Academy of Otolaryngology - Head and Neck Surgery, Inc. (AAO-HNS) Abt study covered 800 codes, 417 of which are considered to be primary otolaryngology codes, and 100 of which were discussed in detailed comments to HCFA for the five-year review. These 100 codes represent approximately 10 percent of the universe of otolaryngology - head and neck surgery services. The comments reflect the opinions of about 40 AAO-HNS members with expertise in the services chosen.

In April, the RUC's Research Subcommittee reviewed the methodology used by Abt and concluded that the RUC should consider a survey of representative codes using RUC methodology to validate the relationship of the Abt-developed relative values to RUC-developed relative values. The AAO-HNS surveyed and submitted recommendations for 53 codes using the RUC methodology. The survey response rate was low for many of the codes originally commented on during the public comment phase and, therefore, AAO-HNS chose to withdraw these codes from the RUC review.

The RUC was concerned by the lack of compelling evidence for many of the services presented by AAO-HNS and recommends that their current value be maintained. Problems identified by the RUC for these services were that: survey results for preservice and postservice time appear to be overstated; inappropriate reference services with different global periods were used; the only argument was that the patient population presented increased risk of HIV and Hepatitis to the physician; the patients had previous radiation treatment; and, acceptable vocal cord capability is now more important to patients. In addition, many recommendations were made to increase the current work RVUs but the AAO-HNS data was very similar to the Harvard time data. The RUC also did not find the argument that intra-service work per unit time (IWPUT) was understated, without any other evidence, a compelling reason to increase the RVUs.

The RUC is recommending increased work RVUs for 30 codes to correct rank order anomalies, address problems where AAO-HNS surveys confirm that the intra-service time for the procedure was underestimated in the Harvard study, and where the patient population has changed in the past five years making the services more complex.

The American Academy of Oral and Maxillofacial Surgeons (AAOMS) and the American Society of Plastic and Reconstructive Surgeons, Inc. (ASPRS) also submitted comments to HCFA and presented recommendations to the RUC for some of the codes in this section.

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
21025	Excision of bone, lower jaw	5.03	8.92	Code is similar to code 24134 <i>Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus</i> (Work RVU = 8.98)	A rank order anomaly exists between this service and 21030 <i>Excision of benign tumor or cyst of facial bone other than mandible</i> (current = 7.05; recommended = 6.04) and 21041 <i>Excision of benign cyst or tumor of mandible; complex</i> (current = 5.03; recommended = 6.04). 21025 has never been surveyed. The AAOMS survey median for intra-service time is 120 minutes, which is significantly higher than 21041 (90 minutes) and reference service 24134. The RUC recommends that the AAOMS survey median of 8.92 be adopted.	1
21031	Remove exostosis, mandible	2.01	3.14	Code is similar to code 21032 <i>Excision of maxillary torus palatinus</i> (RVU = 4.27) in complexity and intraoperative time.	The RUC agrees that code 21031 and 21032 are identical in work and should be valued the same. However, the proposed value of 5.30 is too high when reviewing intra-work intensity. The frequency of codes 21031 and 21032 are approximately equal and should have a work neutral blended value of 3.14. Recommend to HCFA that code 21032 be included in the five-year review.	4
21032	Excision of exostosis, maxilla	4.27	3.14	N/A		5 add
21041	Removal of jaw bone lesion	5.03	6.04	Code is similar to 21030 <i>Excision of benign tumor or cyst of facial bone other than mandible</i> (Work RVU = 7.05) in intraoperative time and complexity.	21041 and 21030 are identical in work and should be valued the same. The frequency of codes 21041 and 21030 are approximately equal and should have a work neutral blended value of 6.04. Recommend to HCFA that code 21030 be included in the five-year review.	4
21030	Removal of face bone lesion	7.05	6.04	N/A		5 add

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
21110	Interdental fixation	5.03	5.03	This service should be the sum of codes 21497 <i>Interdental wiring, for condition other than fracture (does not include removal (3.61) and 20670 Removal of implant; superficial (eg, buried wire, pin or rod) (Separate procedure) (1.69).</i>	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
21150	Reconstruct midface, lefort	24.41	24.41	This service requires more intra-service work than 21433 <i>La Fort III:fracture repair (23.69)</i> and relates more closely to 61526 <i>Craniectomy (29.70)</i> and 33513 <i>Coronary Artery Bypass (30.12)</i> in risk, time, and intensity.	Society did not have adequate survey response and has withdrawn recommendation	2
21188	Reconstruction of midface	21.47	21.47	This service is comparable to 21147 <i>Reconstruction midface, LeFort I; three or more pieces, any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies).</i>	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
21194	Reconstruct lower jaw bone	18.81	18.81	This service is similar to 21193 <i>Reconstruction of mandibular ramus, horizontal, vertical, "C" or "L" oteotomy, without bone graft (16.23)</i> except that 21193 also includes the harvesting and insertion of a bone graft. 21194 should be equal to 21193 plus 50% of 20902 <i>Bone graft, any donor area; major or large (6.74).</i>		2
21243	Reconstruction of jaw joint	18.98	18.98	Code is somewhat more complex than 21247 <i>Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia), from another site (Work RVU = 21.15)</i>	The work RVU was increased during HCFA's refinement process for the 1993 MFS. No compelling evidence was provided that the work has changed since 1992.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
21270	Augmentation cheek bone	12.10	12.10	AAOMS commented in the public comment process that codes 21125 and 21270 were identical in work.	The society was under the impression that it could only survey a few of its most frequently performed services and chose not to survey these codes. No other medical society chose to survey. AAO-HNS, ASPRS, and AAOS do not agree with the AAOMS comment and stated that there is less aesthetic work in the mandible and therefore the RVU for 21270 should be higher than 21125.	2
21125	Augmentation lower jaw bone	6.22	6.22			The RUC recommends the current value be maintained, but will allow all interested providers to review both services for the February meeting.
21320	Treatment of nose fracture	1.82	1.82	This service requires less intra-service time than 30520 <i>Septoplasty</i> (5.55), but there is greater concern about stability and cosmetic result. Due to the traumatic nature of the procedure, there is also less control of the final result.	Society did not have adequate survey response and has withdrawn recommendation	2
21330	Repair of nose fracture	5.03	5.03	This service requires at least twice the time of both 30520 <i>Septoplasty</i> (5.55) and <i>Revision Rhinoplasty</i> (11.23). There is greater risk of injury to the surrounding tissue, because of the use of the drill.		2
21338	Repair nasoethmoid fracture	6.04	6.04	This service was compared to codes 21365 <i>Zygomatic complex fracture</i> (13.97), 31205 <i>External Ethmoidectomy</i> (9.65) and 21386 <i>Open Repair of Orbital Floor Fracture - Periorbital Approach</i> (8.56).		2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
21339	Repair nasoethmoid fracture	7.56	7.56	This service was compared to codes 21365 <i>Zygomatic complex fracture</i> (13.97), 31205 <i>External Ethmoidectomy</i> (9.65) and 21386 <i>Open Repair of Orbital Floor Fracture - Periorbital Approach</i> (8.56).	Society did not have adequate survey response and has withdrawn recommendation	2
21435	Repair craniofacial fracture	16.12	16.12	This service is comparable to 15755 <i>Free flap (microvascular transfer)</i> (28.33), considering that once one has attained a certain level of competence, microvascular anastomosis becomes less intense, although it remains more precise. The physical effort for 21435 is more intense throughout this procedure and failure of adequate reduction compromises both appearance and masticatory function, often requiring further extensive surgery.		2
21453	Treat lower jaw fracture	5.18	5.18	An individual oral and maxillofacial surgeon commented that this service was undervalued in comparison to 66984 <i>Remove cataract with lens placement</i> (9.89).	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
21462	Repair lower jaw fracture	9.15	9.15	AAOMS: This code is undervalued and should be equal to its current value plus 50% of code 21453 <i>Closed treatment of mandible fracture with interdental fixation</i> (5.18). The CPT definition for this code indicates that removal of fixation is not included, however, several Medicare carriers interpret the removal to be included. An individual oral and maxillofacial surgeon commented that this service was undervalued in comparison to 66984 <i>Remove cataract with lens placement</i> (9.89).		2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
21485	Reset dislocated jaw	3.73	3.73	The RVU for this code should equal 21453 <i>Closed treatment of mandibular fracture with interdental fixation</i> (5.18) plus 50% of 21480 <i>Closed treatment of temporomandibular dislocation; initial or subsequent</i> (5.50).	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
30020	Drainage of nose lesion	1.38	1.38	This service is similar to 11603 <i>Excision of malignant lesion of the trunk, arms or legs; lesion diameter: 2.1 or 3.0 cm</i> (2.30).	The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
30545	Repair nasal defect	10.89	10.89	This service is more work than 42200 <i>Palatoplasty for cleft plate, soft, and for hard palate only</i> (9.38) as there is much more dissection than for repair of a cleft palate. Many of the incisions and maneuvers are the same, but with extensive bony work to remove the atresia plate.	Society did not have adequate survey response rate and has withdrawn recommendation.	2
30903	Control of nosebleed	1.54	1.54	The intra-service work of these services is comparable to 42970 <i>Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cauterization</i> (work RVU = 4.78). AAO-HNS also argued that the risk to the physician of HIV and Hepatitis exposure in controlling the nasal hemorrhage has increased the work of the service.	The AAO-HNS survey median time was very similar to the Harvard survey time. The use of 42970 as a reference service is problematic as it has a global period of 090, while these codes have a 000 global period. The presentation that the work has changed due to increased risk of HIV and Hepatitis was not compelling. Many surgical procedures and other services have also been affected by these increased risks.	2
30905	Control of nosebleed	1.97	1.97			2
30906	Repeat control of nosebleed	2.45	2.45			2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
30920	Ligation upper jaw artery	7.46	8.79	This service is similar to 69631 <i>Tympanoplasty</i> (9.55) as both services involve microscopic surgery with similar amounts of skill and time required.	<p>This service is similar to 60220 <i>Total thyroid lobectomy, unilateral; with or without isthmusectomy</i> (work RVU = 9.86) and 31075 <i>Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type)</i> (work RVU = 8.57). Increased mental effort and technical skill is required due to the possibility of complications such as ligation of the optic nerve. Patients have been previously packed and tend to have advance sinusitis and a large amount of mucous membrane which will make the procedure very difficult.</p> <p>The AAO-HNS survey resulted in 42 more minutes of intra-service time than Harvard. The Harvard survey may not have reflected the difficult patient population.</p>	1

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
31225	Removal of upper jaw	15.19	17.50	This service is similar to 21433 <i>Repair craniofacial fracture (23.69)</i> as the intra-operative time is the same and there is similar intensity in attempting to avoid iatrogenic injury to the orbit.	The current proportionality between the work RVUs for these two codes is incorrect. 31225 is a smaller operation than 31230 <i>Maxillectomy; with orbital exenteration (en bloc)</i> (work RVU = 21.06) but requires more technical skill and mental effort as preserving the orbit is more difficult than removing it. The AAO-HNS survey median suggests that the ratio of 31230 to 31225 should be 1.15. The RUC recommends a work neutral recommendation of 17.50 for 31225 and 20.00 for 31230.	4
31230	Removal of upper jaw	21.06	20.00	This service is more work than 21433 <i>Repair craniofacial fracture (23.69)</i> as there is considerably more blood loss and there is a real potential for entrance into the intracranial cavity during the operation.		5

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
31290	Nasal/sinus endoscopy, surg	12.87	16.05	The overall intensity of these procedures is higher than the average case of endoscopic sinus surgery, since the surgery is being performed in the presence of a skull base defect and the possibility of creating an intracranial lesion is even more immediate.	Nasal/sinus endoscopy recommendations were developed by the RUC in 1993. HCFA subsequently decreased the value for many of the recommendations, based largely on erroneous crosswalk and frequency information. HCFA corrected the values for the more frequently provided diagnostic services in this family of codes but suggested that AAO-HNS might comment on these five services in the five-year review. AAO-HNS has re-surveyed these services and submits new values based on its survey median. Four of the recommendations are lower than the original RUC recommendations and one (31294) is higher. The intra-service work per unit time appears reasonable for these services. The rank order will be different than the original RUC recommendations for these codes, however, AAO-HNS and the RUC agree that it is now correct	1
31291	Nasal/sinus endoscopy, surg	13.52	17.00			1
31292	Nasal/sinus endoscopy, surg	10.45	13.83			1
31293	Nasal/sinus endoscopy, surg	11.43	15.15			1
31294	Nasal/sinus endoscopy, surg	13.06	18.00			1
31320	Diagnostic incision larynx	4.54	4.54			This service is comparable to exposure of the thyroid gland prior to its resection . It exceeds the level of intensity for exposure of the submandibular gland. Thyrotomy approximates 60240 <i>Thyroidectomy</i> (15.66) in time and intensity.

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
31360	Removal of larynx	15.19	15.19	These services require similar time and knowledge as 45110 <i>Proctectomy, AP resection with colostomy</i> (21.68). There may also be a slightly higher possibility for intraoperative blood loss with proctectomy but there is not the concern over airway obstruction occurring during the induction of anesthesia.	The AAO-HNS argument that the patient population for these services has changed in the past five years as it is now performed on patients following radiation therapy was not compelling. Many other procedures are affected by this changing patient population.	2
31365	Removal of larynx	21.83	21.83			2
31367	Partial removal of larynx	18.98	18.98	This service is similar to 55845 <i>Retropubic prostatectomy and pelvic node dissection</i> (26.73) in time and identification and preservation of anatomy. Complex anatomy must be resected and preserved while removing pathologic tissue.	Society did not have adequate survey response and has withdrawn recommendation	2
31368	Partial removal of larynx	23.72	23.72	This service is more technically demanding than 50230 <i>Nephrectomy</i> (20.56) because the physician must preserve the vocal and swallowing functions while removing cancerous tissue.		2
31370	Partial removal of larynx	18.50	18.50	This service is similar to 61510 <i>Craniotomy for brain tumor, supertentorial</i> (23.39) as both procedures require performing preliminary work, one tracheostomy, the other burr holes. Both require bone and cartilaginous cuts and flaps, perichondrium or dura, excised and developed. Both require resection of areas vital to normal life functions. One with airway protection, speech and deglutition function. The laryngeal post op function is critically dependent upon the technical execution of the operation. This same type of technical skill is not needed in a craneotomy.		2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
31380	Partial removal of larynx	18.50	18.50	This service is more work than <i>Prostatectomy</i> (21.68). The hemilaryngectomy is perceived to be more intense and technically more precise in the intraoperative decision making. Prostatectomy does not require as much precision for success and continued functional voicing ability. Both procedures require bypass procedures while healing occurs.	Society did not have adequate survey response and has withdrawn recommendation	2
31382	Partial removal of larynx	18.50	18.50	This service is comparable to 51596 <i>Cystectomy complete, with reconstruction of neobladder</i> (36.27). Both procedures require extraction of functionally important structures with reconstruction of a plastic nature in order to allow preservation and function of important bodily functions. The approach and exposure of the bladder procedure is more difficult and therefore takes more time.		2
31390	Removal of larynx & pharynx	21.15	25.00	This service was compared to 31766 <i>Reconstruction of windpipe</i> (48.34) and 38765 <i>Remove groin lymph nodes</i> (30.07).	<p>A rank order anomaly currently exists between this service and code 31365 <i>Laryngectomy; total, with radical neck dissection</i> (work RVU = 21.83). Code 31390 is more work than 31365 as it requires performing a pharyngolaryngectomy.</p> <p>In addition, the AAO-HNS survey intra-service time was 40 minutes greater than Harvard data. The final Harvard value is 25.33.</p>	1

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
31395	Reconstruct larynx & pharynx	26.19	28.00	This service was compared to 31766 <i>Reconstruction of windpipe</i> (48.34) and 38765 <i>Remove groin lymph nodes</i> (30.07).	<p>The role of reconstruction and post-service work is currently undervalued in this procedure. The RVU for this service should be equal to 31390 and the additional work of placing either a free tissue graft, myocutaneous flap, or other reconstructive techniques, such as a free gastric patch in place, using microvascular techniques. The reconstructive technique is billed separately, however, there is extra work in suturing the device. Additionally, all reconstructive techniques fail to provide sensation to the pharynx following reconstruction which leads to aspiration and difficulty in feeding. This service requires additional post-service time to coordinate with swallowing experts and counsel the family and patient.</p> <p>The AAO-HNS survey intra-service time was 76 minutes greater than Harvard data. The number and length of hospital visits was also significantly more. The final Harvard value is 29.62.</p>	1
31400	Revision of larynx	9.06	9.06	This service requires more time to perform the entire procedure and requires considerably more intensity in performing the movement and fixation of the vocal cord. There is also considerably more risk involved in the procedure in terms of airway problems, decreased voice performance and risk of aspiration.	Society did not have adequate survey response and has withdrawn recommendation	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
31502	Change of windpipe airway	0.65	0.65	An individual commented that this service is undervalued in comparison to 31730 <i>Transtacheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy (2.85)</i> .	The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
31513	Injection into vocal cord	2.10	2.10	This service is more work than 41822 <i>Excision of gum lesion (2.26)</i> because it requires considerable more skill in placing the injection and is more intense.		2
31531	Operative laryngoscopy	3.73	3.79	The RUC identified rank order anomalies in this family of codes. Although the AAO-HNS had not submitted individual comments on 31531 and 31536, they were included in the Abt study submitted to HCFA.	<p>The AAO-HNS argued that the patient population had changed for these services in the past five years. There is a greater emphasis on an acceptable vocal result following this type of surgery.</p> <p>The Argument to increase the RVU to reflect increased pressures in preserving vocal content was not compelling. However, the RUC determined that rank order anomalies exist in this family of codes. The RUC reviewed the Abt study for AAO-HNS to determine an appropriate increment for the "add-on" for providing this service with an operating microscope. The RUC agreed that .40 was an appropriate increment and added this to the parent code's current RVU throughout the family as follows:</p> <p>31530 3.39 +.40 31531 3.79 31535 3.16 +.40 31536 3.56 31540 4.13 +.40 31541 4.53 31560 5.46 +.40 31561 5.86 31570 3.87 +.40 31571 4.27</p>	4 add
31536	Operative laryngoscopy	3.17	3.56			4 add

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
31541	Operative laryngoscopy	3.56	4.53	This service is similar to 39400 <i>Mediastinoscopy with or without biopsy</i> (5.11). The airway is protected in the mediastinoscopy and not in laryngoscopy. Both require similar instrumentation. The mediastinoscopy requires an incision, but the complexity of the procedure is offset by the complexity of airway management in the laryngoscopy. The care and preciseness of the procedure is much greater with the biopsy and tumor removal of the larynx.	See previous page	4
31561	Operative laryngoscopy	4.90	5.86	This service is more work than 54520 <i>Orchiectomy, simple</i> (4.93) as there is much more intensity in the arytenoid resection than in the simple orchiectomy. Arytenoidectomy requires significantly more judgement and carries considerable more immediate and possible long term risk.		4
31571	Laryngoscopy with injection	3.52	4.27	This service is more work than 42820 <i>Tonsillectomy/adenoidectomy; under age 12</i> (3.59) as both require careful technique, both involve topical anesthetization requiring establishing careful rapport with a conscious patient. The actual injection requires more a intense precision and exacting technique.		4
31580	Revision of larynx	11.01	11.01	This service is similar to 40701 <i>Cleft lip, nasal deformity repair</i> (15.10) as a similar amount of time and intensity in the intra-service period is required. Both procedures require a great deal of precision, work on a delicate anatomic structure such as the nose or larynx.	AAO-HNS survey data was very similar to the Harvard data. No other compelling evidence was presented.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
31587	Revision of larynx	7.98	10.00	The most appropriate reference services for this code are the laryngectomy codes (CPT 31360 - 31382). This service should be valued at 40-50% of these services.	<p>The changing patient population of neonates warrants an increase for this service. Infants who ordinarily would have been a candidate for a tracheotomy are now have been subjected to cricoid split as an alternative. This procedure has the same risk of pediatric tracheotomy and the risks of maintaining endotracheal intubation in the face of an open tracheal wound. There is significant risk of pneumothorax as well as air way loss should the endotracheal tube become dislodged.</p> <p>In addition, AAO-HNS survey intra-service time is 25 minutes greater than Harvard data.</p>	1
31600	Incision of windpipe	3.62	3.62	This service is comparable to 54520 <i>Orchiectomy, simple with or without testicular prosthesis, scrotal or inguinal approach</i> (4.93) and 39400 <i>Mediastinoscopy, with or without biopsy</i> (5.11). Both orchiectomy and mediastinoscopy take approximately one hour. In the case of mediastinoscopy, the anatomy is similar to a tracheostomy. In an orchiectomy with replacement of testicular prosthesis, the proper prosthesis must be selected for the patient's size just as the proper tracheostomy needs to be selected and checked.	The AAO-HNS argument that the patient population has changed is not convincing. The intra work per unit time already appears high. The Harvard data for intra-service time appears to be more accurate than the AAO-HNS survey data.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
31601	Incision of windpipe	4.45	4.45	This service is comparable to 34201 <i>Embolectomy or thrombectomy, femoropopliteal, aortoliac artery, bileg incision</i> (8.04) in intra-service time. Both procedures require selection of the proper device and have significant risks association with them such as loss of an extremity or airway obstruction. The intensity this procedure in one hour is comparable to a neonatologist's day of evaluation and management services of a critically ill and unstable neonate or infant.	The argument that the patient population has changed is not convincing. The intra work per unit time and Harvard data appears reasonable.	2
31603	Incision of windpipe	4.15	4.15	An emergency tracheostomy is comparable to 35207 <i>Repair of blood vessel</i> (9.06) and 49000 <i>Exploratory laparotomy</i> (8.99). 35207 involves a limited amount of time to restore the blood flow to the severed digit or hand. 49000 requires quick decision making as the surgeon must be prepared to deal with unexpected findings.		2
31610	Incision of windpipe	7.87	7.87	This service is comparable to 43420 <i>Closure of fistula</i> (10.19) in terms of anatomy, length of time, and consideration of patient's ability to swallow.	Society did not have adequate survey response and has withdrawn recommendation	2
31611	Surgery/speech prosthesis	5.03	5.03	This service is comparable to 43831 <i>Place gastrostomy tube</i> (12.54).		2
31614	Repair windpipe opening	6.11	6.11	This service is comparable to 15240 <i>Skin full graft procedure</i> (8.30).	The AAO-HNS survey data is similar to Harvard data. No other compelling evidence was presented.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
31750	Repair of windpipe	9.05	11.73	This service is comparable to 43331 <i>Esophagomyotomy</i> (14.73).	<p>The Harvard survey underestimated intra-service time of this service. The patient population has also become more complex.</p> <p>The RUC did not agree with the recommended value of 15.00 and computed a new RVU by adding 69 minutes additional intra-service time in the AAO-HNS survey multiplied by the Harvard IWPUT to the current value.</p>	4
31780	Reconstruct windpipe	16.14	16.14	This service is comparable to 43312 <i>Esophagoplasty</i> (27.26).	<p>This code was included in the 1992 refinement process and the RVU was increased from 13.18 to 16.53.</p> <p>The evidence presenting regarding the increased complexity in the patient population was not compelling.</p>	2
38720	Removal of lymph nodes, neck	12.29	12.29	This service is comparable to 42415 <i>Excision of parotid tumor or parotid gland, lateral lobe with dissection and preservation of the facial nerve</i> (16.12) and 60240 <i>Thyroidectomy, total or complete</i> (15.66) in both time and skill. The pressure involved in the complete neck dissection is far greater than that of 42415 or 60240, because the potentially catastrophic consequences of injuring any of the nervous structures, jugular vein, carotid artery or the thoracic duct.	<p>Harvard intra-service time is greater than AAO-HNS data. Survey data does not support rationale for increasing the current value.</p> <p>Endoscopy is not included in the work of this service.</p>	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
38724	Removal of lymph nodes, neck	13.22	13.22	This service is more work than 42415 <i>Excision of parotid tumor or parotid gland, lateral lobe with dissection and preservation of the facial nerve</i> (16.12) and 60240 <i>Thyroidectomy, total or complete</i> (15.66) in both time and skill.	No compelling evidence presented to increase value.	2
40806	Incision of lip fold	0.31	0.31	This service is similar to 41010 <i>Incision of lingual frenum (frenotomy)</i> (1.19).	The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
40808	Biopsy of mouth lesion	0.91	0.91	This service is similar to 11441 <i>Removal of skin lesion, benign, less than 1 cm</i> (1.56).		2
40820	Treatment of mouth lesion	1.23	1.23	AAO-HNS: This service is similar to 42808 <i>Excision or destruction, lesion of pharynx posterior pharynx</i> (2.25). An individual commented that this service may be overvalued in comparison to 17000 <i>Destruction by any method, including laser, with or without surgical curettage, all benign facial lesions or premalignant lesions in any location, or benign lesions other than cutaneous vascular proliferative lesions, including local anesthesia; one lesion</i> (0.64).		2
40843	Reconstruction of mouth	11.63	11.63	This service is similar to 40842 <i>Vestibuloplasty; unilateral</i> (8.31), but is more complex and requires more intraoperative time since the procedure is performed bilaterally and through separate incisions.		2
41000	Drainage of mouth lesion	1.25	1.25	This service is similar to 36140 <i>Introduction of needle or intracatheter; extremity artery</i> (2.01).		2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
41005	Drainage of mouth lesion	1.21	1.21	AAOMS: This service is similar to 42325 <i>Fistulization of sublingual salivary cyst (ranula)</i> (2.65). AAO-HNS: This service is similar in work to 92004 <i>Ophthalmological services, medical examination and evaluation wit initiation of diagnostic and treatment program, comprehensive, new patient, one or more visits</i> (1.61).	The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
41112	Excision of tongue lesion	2.63	2.63	This service is similar to 46255 <i>Hemorrhoidectomy, internal or external simple</i> (4.95).		2
41113	Excision of tongue lesion	3.09	3.09	This service is more work than 46255 <i>Hemorrhoidectomy, internal or external simple</i> (4.95).		2
41115	Excision of tongue fold	1.69	1.69	This service is similar to 40819 <i>Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)</i> (2.26).		2
41116	Excision of mouth lesion	2.36	2.36	This service is similar to 46255 <i>Hemorrhoidectomy, internal or external simple</i> (4.95).		2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
41135	Tongue and neck surgery	14.29	21.15	This service is similar to 31365 <i>Laryngectomy and neck dissection</i> (21.83) and 30160 <i>Total Rhinectomy and neck dissection</i> combined with 38720 <i>Removal of lymph nodes, neck</i> (8.92 + 12.29).	<p>This procedure is complex due to the work of performing the surgery under the cover of the mandible. Previously, additional exposure could be afforded by dividing the patients lower lip, which is no longer acceptable to patients. The exposure for this type of surgery is now more limited.</p> <p>AAO-HNS and Harvard intra-service time is very similar. The final Harvard value is 20.35. The Intra-service work per unit time in the AAO-HNS survey appears reasonable. The RUC recommends the AAO-HNS survey median.</p>	1
41145	Tongue removal; neck surgery	27.58	27.58	The intensity of the work for this service is similar to 31395 <i>Laryngopharyngectomy with neck dissection and reconstruction</i> (26.29) and 31225 <i>Total maxillectomy and neck dissection</i> combined with 38720 <i>Removal of lymph nodes, neck</i> (15.19 + 12.29). The time may be 60-75 minutes longer for laryngopharyngectomy and neck dissection and 60 minutes less for maxillectomy with neck dissection.	Society did not have adequate survey response and has withdrawn recommendation	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
41150	Tongue, mouth, jaw surgery	19.36	21.00	This service involves more time than 31225 <i>Maxillectomy without orbital exenteration</i> (15.19). 31225 was also included as an undervalued service in the AAO-HNS comments to HCFA and the RUC has recommended an increase to 17.50.	The number of patients presenting for this surgery following radiation therapy has increased in the past five years. This has placed additional demands on the surgeon, both at the time of the procedure due to technical problems with radiated tissue, as well as the threat of post operative fistula formation.	1
				Close to 41140 in total work		
41155	Tongue, jaw, & neck surgery	23.40	25.60	This service involves less time, but is comparable to 31395 <i>Laryngopharyngectomy and neck dissection with reconstruction</i> (26.19). 31395 was included as an undervalued service in the AAO-HNS comments to HCFA and the RUC has recommended an increase to 28.00.	AAO-HNS Intra-service time is very similar to Harvard data. Harvard recommended an RVU of 20.85 for 41150 and 25.43 for 41155. Intra-service work per unit time appears reasonable. The RUC recommends the AAO-HNS survey median.	1
				Increment over 41150 should be greater than 41145 over 41140.		
41252	Repair tongue laceration	2.92	2.92	This service is comparable to 45380 <i>Colonoscopy, flexible, proximal to splenic flexure with biopsy</i> (4.01). The average colonoscopy takes 30-45 minutes, which includes obtaining the biopsy. There is no risk of airway obstruction with a colonoscopy, although, there is a risk of bowel perforation.	Society did not have adequate survey response and has withdrawn recommendation	2
42106	Excision lesion, mouth roof	2.63	2.05	Increment over reference services 42100 <i>Biopsy roof of mouth</i> (rvu = 1.26) and 42104 <i>Excision lesion, mouth roof</i> (rvu = 1.59) is too great. A simple closure following excision of a lesion is less than .50 RVUs.	The AAOMS, AAO-HNS, and AAD all agreed with the CMD recommendation. The RUC recommends that HCFA reduce the current RVU.	3

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
42120	Remove palate/lesion	5.39	5.39	This service is comparable with 42700 <i>Palatoplasty for cleft palate, soft and/or hard palate only</i> (9.48).	The Harvard data for this service is very similar to the AAO-HNS survey data. No other compelling evidence presented to increase value.	2
42145	Repair,palate,pharynx/uv ula	7.04	7.04	This service is comparable with 42700 <i>Palatoplasty for cleft palate, soft and/or hard palate only</i> (9.48).	<p>The Harvard intra-service time is the same as the AAO-HNS survey. The RUC was not convinced that the pre-, and post-service time has increased for this service.</p> <p>In response to a HCFA question, the RUC confirmed that this is not the correct code for reporting this procedure performed by laser in the office. There is currently no CPT code for this service. Most insurance plans consider the laser technique experimental.</p> <p>It was also noted that the increased frequency of claims for this service is due to patient self-referrals and the growth of sleep centers.</p>	2
42182	Repair palate	3.78	3.78	This service is similar in scope, intensity, and time to 30520 <i>Septoplasty or submucous resection with or without cartilage scoring, contouring or replacement with graft</i> (5.55).	Society did not have adequate survey response and has withdrawn recommendation	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
42200	Reconstruct cleft palate	9.48	11.25	This service is undervalued when compared to 58260 <i>Vaginal hysterectomy</i> (11.39) and 47605 <i>Cholecystectomy</i> (11.53).	<p>This service closely approximates the stress, technical skill and mental effort of 40700 <i>Repair of cleft lip</i> (rvu= 12.04).</p> <p>This service is performed on a pediatric population and increasingly on a younger population (6-9 months). The stress and technical skill has increased, as this service is performed using a the new furrow technique requiring two Z-plasties in two different planes turned in two different directions. This technique involves a steep learning curve. In addition, this service involves greater stress due to iatrogenic risk to the patient.</p> <p>A proportionality problem also exists between this service and other services in this family of codes. After reviewing Harvard data and intensity, the RUC recommends 11.25.</p>	4
42210	Reconstruct cleft palate	10.02	13.75	This service is a complex code which encompasses work described in 42205 <i>Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only</i> (8.96) plus half the value of 20903 <i>bone graft, any donor; major or large</i> (6.74).	<p>This service is comparable to 42200 with an additional increment for the bone graft that is included in the service.</p> <p>The RUC calculated a new value by adding 50% of code 20900 <i>Bone graft, any donor area; minor or small (eg, dowel or button)</i> (rvu = 5.09) to the recommend value for 42200.</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
42260	Repair nose to lip fistula	4.17	9.18	This service is similar to 30600 <i>Repair fistula, oranasal</i> (5.87). They involve similar intraoperative time and postoperative care.	This service was not surveyed by Harvard. 42260 is more work than 14040 <i>Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less</i> (rvu = 7.18) and 14060 <i>Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less</i> (8.05) as it requires extra technical expertise in a tiny difficult location. The double flap is laid in a bipolar fashion which requires more mental effort in planning and execution than 14040 and 14060.	1
42305	Drainage of salivary gland	5.59	5.59	This service is comparable to 29881 <i>Arthroscopy, knee</i> (7.46)	The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
42320	Drainage of salivary gland	2.30	2.30	This service is comparable to 42820 <i>Tonsillectomy</i> (3.59).		2
42340	Removal of salivary stone	4.47	4.47	This service is comparable to 26531 <i>Arthroplasty</i> (7.57).		2
42415	Excise parotid gland/lesion	16.12	16.12	The American Society of General Surgeons (ASGS) included this service in a list of codes submitted in their public comment letter. The ASGS comments were based on a study using the whipple procedure as a benchmark.	Society did not have adequate survey response and has withdrawn recommendation	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
42426	Excise parotid gland/lesion	19.88	19.88	This service is more work than 42415 <i>Lateral parotidectomy, dissection and preservation of the facial nerve</i> (16.12). 42426 is typically performed for high grade malignancies or extensive benign lesions, which requires far more extensive dissection around the facial nerve and higher risk of post-op nerve injury than 42415 which is performed for benign or low grade malignancies.	Society did not have adequate survey response and has withdrawn recommendation	2
42500	Repair salivary duct	4.06	4.06	This service is comparable to 35207 <i>Repair blood vessel, direct; hand, finger</i> (9.06) since both are usually traumatic, require surgical exploration to find proximal and distal end, and require precise surgical closure.		2
42505	Repair salivary duct	5.92	5.92	This service requires more time and work than 35207 <i>Repair blood vessel, direct; hand, finger</i> (9.06).		2
42507	Parotid duct diversion	5.96	5.96	This service is slightly less work than 54326 <i>Urethral reconstruction</i> (14.81).	The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
42508	Parotid duct diversion	8.64	8.64	This service is more work than 54326 <i>Urethral reconstruction</i> (14.81) and 42440 <i>Excision of submandibular gland</i> (6.61) combined.		2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
42720	Drainage of throat abscess	2.61	4.53	This service requires more mental effort, skill, and stress than 42820 <i>Tonsillectomy/adenoidectomy</i> (3.59).	<p>The Harvard data for this service failed to take into account the amount of pre-service work and immediate post-service work involved in this procedure. The intra-service component failed to capture the increased stress and anxiety due to the potential for airway compromise, aspiration and cardiac arrest.</p> <p>The RUC agreed that this code is currently undervalued and calculated a new value by adding 30 minutes of post-service work to the Harvard survey data.</p>	4
42725	Drainage of throat abscess	7.60	9.50	This service is comparable to 43420 <i>Cervical Esophagostomy Closure</i> (10.19).	<p>This service is similar in work to 60220 <i>Total thyroid lobectomy, unilateral; with or without isthmusectomy</i> (rvu = 9.86). The pre-service work is greater due to the need to consult other care givers regarding an individual who is toxic and possibly septic. The intra-service intensity is similar, however, the time needed to perform 60220 is much greater than 42725. The principal difference between these two services appears to be in the post-service work. 42725 requires nine post-operative visits and will include continued monitoring of the patient's general status with regard to antibiotic prophylaxis and treatment, as well as advancing drains and handling the wound complications.</p>	1

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
42809	Remove pharynx foreign body	1.76	1.76	This service is comparable to 31511 <i>Laryngoscopy, indirect (separate procedure); with removal of foreign body</i> (2.16).	Society did not have adequate survey response and has withdrawn recommendation	2
42815	Excision of neck cyst	6.75	6.75	This service is comparable to 43420 <i>Closure of esophagostomy or fistula, cervical approach</i> (10.19) as the time for the branchial tract dissection should be slightly longer and the intensity should be considerable greater, due to the variable course of the tract with vital structures close to all portions of the tract.		2
42820	Remove tonsils and adenoids	3.59	3.59	An individual commented during the public comment process that this service is comparable in work to 46250 <i>Hemorrhoidectomy, external, complete</i> (rvu = 5.00). AAO-HNS also responded that the work of providing this service has changed in the past five years. This is a reflection of the delay in referral for tonsillectomy and adenoidectomy, along with the general increased severity of children presenting for this surgery. The site-of-service has changed, according to 90% of the survey respondents, from inpatient to outpatient. This demands more follow-up calls and shifts the responsibility for patient education from the hospital to the physician's office.	The RUC was not convinced that the patient population for this service has become more complex. The Harvard time for this procedure is comparable to the AAO-HNS survey data.	2
42961	Control throat bleeding	5.18	5.18	This service is comparable to 42440 <i>Excision of submandibular gland</i> (6.61).	Society did not have adequate survey response and has withdrawn recommendation	2
42962	Control throat bleeding	6.64	6.64	This service is comparable to 49000 <i>Exploratory laparotomy</i> (8.99).		2
42972	Control nose/throat bleeding	6.55	6.55	This service is comparable to 49262 and should also be increased to 9.00.		2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
43200	Esophagus endoscopy	1.59	1.59	This service is comparable to 31622 <i>Bronchoplasty</i> (2.80).	Society did not have adequate survey response and has withdrawn recommendation	2
60225	Partial removal of thyroid	11.65	13.31	Closer to the work of 60240 <i>Thyroidectomy, total or complete</i> (rvu = 15.66) Recommend value that is 15% less.	The RUC agrees with the CMD recommendation.	1
60240	Removal of thyroid	15.66	15.66	This service is comparable to 42415 <i>Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve</i> (rvu = 16.12). In both cases cancer is usually the indication for surgery and both carry the risk of nerve injury. Although post operatively, both need observation, but need little care, once the immediate post operative potential problems are overcome.	The ASGS survey data is very similar to the Harvard data. No other compelling evidence presented to increase value.	2
60252	Removal of thyroid	15.40	17.23	Closer to the work of 60240 <i>Thyroidectomy, total or complete</i> (rvu = 15.66) Recommend value gives 10% more for neck dissection.	The RUC agrees with the CMD recommendations for these services.	1
60254	Extensive thyroid surgery	16.68	22.50	Radical neck dissection is considerable more work than <i>Thyroidectomy, total or complete</i> (rvu = 15.66).		1
64734	Incision of cheek nerve	4.62	4.50	This code is almost exactly the same as code 64736 <i>Transection of mental nerve</i> (4.40). These procedures have the same degree of difficulty and intraoperative time. They should have the same relative value of 4.50.	The RUC agrees with the AAOMS recommendation to decrease the RVU for this service.	3
64736	Incision of chin nerve	4.40	4.40	This service is the same as 64734 <i>Transection or avulsion of infraorbital nerve</i> (4.62). These procedures have the same degree of difficult and intraoperative time. Recommended value of 4.50.	The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
69100	Biopsy of external ear	0.76	0.81	69100, which is site specific, should be the same work as 69120 <i>Excision external ear; complete amputation (rvu=3.95)</i> .	The RUC agreed that these services should be assigned the same work RVU. It should be noted that 11100 went through refinement and was increased for the 1993 MFS.	1
69110	Partial removal external ear	3.34	3.34	An individual commented that this service may be overvalued in comparison to 11100 <i>Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion (0.81)</i> .	The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2
69150	Extensive ear canal surgery	13.01	13.01	The intra-service time and intensity associated with 69150 is at least 2.5 times that associated with 69646 <i>Revise middle ear and mastoid (17.35)</i> .	Society did not have adequate survey response and has withdrawn recommendation	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
69155	Extensive ear/neck surgery	17.03	19.09	The intra-service time and intensity associated with 69155 is at least 2.5 times that associated with 69646 <i>Revise middle ear and mastoid</i> (17.35) and at least 1.5 times that associated with 38720 <i>Cervical lymphadenectomy (complete)</i> (12.29). The risk of a facial nerve injury is considerably higher in performing a partial temporal bone resection.	<p>This service has been inappropriately undervalued due to the lack of realization of the amount of work involved in all three phases of its completion. Particularly, there has been undervaluation of the intra-service component. The technical accomplishment of a neck dissection alone accompanied with a complete mastoidectomy and then enbloc resection of the tympanic membrane, tymbone and external auditory canal with an oncologically safe margin was not realized in the Harvard data. Additionally, post operatively this patient faces all the risks of major operations, as is reflected in the amount of service time and number of visits which will be necessary in the 90 day global period.</p> <p>The RUC agreed that this service was undervalued, but computed a new value by adding 50% of 38720 <i>Cervical lymphadenectomy (complete)</i> (rvu= 12.29) to the current value of 69150 (13.01).</p>	4
69320	Rebuild outer ear canal	16.60	16.60	This service is comparable to 61526 <i>Craniectomy (mastoid) for excision of cerebellopontine angle tumor</i> (29.71).	Society did not have adequate survey response and has withdrawn recommendation	2
69530	Extensive mastoid surgery	18.04	18.04	This service is comparable to 61526 <i>Craniectomy (mastoid) for excision of cerebellopontine angle tumor</i> (29.71)		2

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended increase; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
69535	Remove part of temporal bone	34.50	34.50	A contemporary subtotal or total temporal bone resection differs significantly from that described and performed 10 years ago. The experience and technical improvements realized with more sophisticated cranial base procedures now permit a more efficient, safer, and oncologically-sound removal of the temporal bone.	Society did not have adequate survey response and has withdrawn recommendation	2
69554	Remove ear lesion	25.78	31.27	This service requires slightly more time and intensity than 61530 <i>Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy</i> (42.35).	The work in performing this procedure was not captured in the Harvard data. This service requires a greater amount of time, technical skill and physical effort than key reference service 21433 <i>Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches</i> (rvu = 23.69). The mental effort, judgment and stress involved in resecting glomus tumors, which bleed quite profusely from the delicate structures about the temporal bone, middle ear and jugular bulb, is considerable. The key portion of this service actually involves removal of the jugular bulb with the drainage of the sigmoid sinus, internal jugular vein and inferior petrosal sinus all needing to be controlled simultaneously. Significant blood loss in the range of 6 to 12 units is not unheard of. The RUC agreed that this code is currently undervalued, however, the pre-service time appears to be overstated. The RUC developed a new work RVU by adding the additional intra-service time in the AAO-HNS survey multiplied by the IWPUT to the current value.	4

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
69605	Mastoid surgery revision	18.04	18.04	This service requires more time and intensity than 61312 <i>Craniotomy/trephination for subdural hematoma (20.54)</i> .	Society did not have adequate survey response and has withdrawn recommendation	2
69660	Revise middle ear bone	11.64	11.64	This service is comparable to 42415 <i>Excise parotid gland/lesion (16.12)</i> and 63017 <i>Removal of spinal lamina (15.85)</i> .		2
69661	Revise middle ear bone	15.32	15.32	This service is more work than 42415 <i>Excise parotid gland/lesion (16.12)</i> and 63017 <i>Removal of spinal lamina (15.85)</i> .		2
69662	Revise middle ear bone	15.04	15.04	This service is comparable to 61312 <i>Craniectomy for evacuation of hematoma (20.54)</i> .		2

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended increase; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
69725	Release facial nerve	18.98	24.01	<p>This service is comparable to 61526 <i>Middle cranial fossa craniotomy with exposure of the internal auditory canal and fallopian canal</i> (29.71).</p> <p>This service should be valued closer to 61526 <i>Removal of Brain lesion</i> (rvu = 29.71). It is much more work than 69720 <i>Decompression of facial nerve, intratemporal; lateral to geniculate ganglion</i> (rvu = 13.95).</p>	<p>The Harvard data does not capture the amount of work involved in performing this procedure. The portion of the surgery near the geniculate ganglion is particularly hazardous, due to the fact that at this point the facial nerve is in close proximity to the bony structures of the inner ear-cochlea and semicircular canals. The work involved in this procedure is clearly greater than that of a standard typanoplasty with mastoidectomy (69642 - 16.37) due to the increased technical skill required to safely perform this procedure. There is a very real risk of permanent injury due to the inadvertent damage to the patient's hearing in the cochlea and balance due to potential injury of the semicircular canals.</p> <p>A new RVU was computed by adding 1) 73 minutes of intra-service time multiplied by the IWPUT and 2) 30 minutes additional post-service time multiplied by ICU IWPUT to the current value.</p>	4

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended increase; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
69805	Explore inner ear	10.27	13.18	This service is comparable to 69602 <i>Mastoid surgery revision</i> (13.16).	<p>These services are infrequently performed neurotologic procedures which were underestimated in the Harvard study.</p> <p>The RUC compared these services to 55812 <i>Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)</i> (25.65) which is similar in work and time to 69955 and 69960 and determined that these services are currently undervalued. However, the pre-service time appears to be overstated in the AAO-HNS survey.</p> <p>A new RVU was computed for all of these services by adding 1) the additional minutes in the AAO-HNS survey of intra-service time multiplied by the IWPUT and 2) the additional minutes in the AAO-HNS survey of post-service time multiplied by an IWPUT for visits to the current value. The rank order of the AAO-HNS survey medians was retained.</p> <p>AAO-HNS also noted that aural rehabilitation is not included in the work of this service and would be billed separately.</p>	4
69930	Implant cochlear device	14.00	16.13	This service is comparable to 69646 <i>Revised middle ear and mastoid</i> (17.35). The creation of the cocleostomy and placement of the electrode into the inner ear requires more skill and time compared to the reference service.		4
69950	Incise inner ear nerve	21.15	24.21	This service is comparable to 61526 <i>Transtemporal removal of a brain tumor</i> (29.71).		4
69955	Release facial nerve	22.12	25.54	This service is comparable to the combination of three separate procedures 69950 <i>Middle fossa</i> (21.15), 69643 <i>Intact canal wall mastoidectomy</i> (14.81), and 42415 <i>Lateral lobe parotidectomy with a dissection of the facial nerve</i> (16.12).		4
69960	Release inner ear canal	19.75	25.54	This service is similar to 61526 <i>Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor</i> (29.71) and 61518 <i>Craniectomy for excision of brain tumor, infratentorial or posterior fossa</i> (32.27).		4
69970	Remove inner ear lesion	22.30	28.54	This service is similar to 61530 <i>Craniectomy combined with middle/posterior fossa craniotomy/craniectomy</i> (42.35).		4

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 21025

Global Period: 090 **Current RVW:** 5.03 **Recommended RVW:** 8.98

CPT Descriptor:

Excision of bone (e.g., for osteomyelitis or bone abscess); mandible

Source and Summary of Comment to HCFA on this service:

Code 21025 is similar to code 21030, (Work RVU-7.05) (excision of benign tumor or cyst of facial bone other than mandible), in terms of difficulty, but pre and postoperative visit patterns are significantly more. Code 21025 is also similar to code 24134 (Work RVU-8.98) (Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus and should retain an RVU of 8.98. Source: AAOMS Special Committee on Physician Payment Review Commission.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The procedures performed under this code include removal of sequestrums of nonvital bone from the mandible. Patients present with intra and extra oral swelling and suppuration from one or more fistulas. The procedure includes intra and/or extra oral soft tissue incision to gain access to the affected area. Nonvital bone of the mandible is removed with use of curettage, rongeurs and drills/burs. Continuity of the mandible remains. The inferior alveolar nerve is dissected and preserved. Drains are placed. Soft tissue incisions are closed. I.V. antibiotics and/or hyperbarometric oxygen are initiated with necessary follow up for 90 days. Complications are low but disease may advance, requiring resection, stabilization and bone grafting.

Description of Pre-Service Work:

See patient and family prior to going to operating room, review chart, change and be in operatory to position head, stabilize endotracheal tube, scrub and drape patient.

Description of Intra-Service Work:

Extraoral and intraoral incisions, culture tissues, debridement of nonvital bone, preservation of inferior alveolar nerve, placement of drains, and close incisions.

Description of Post Service Work:

Apply pressure dressings, write orders, dictate operative report, meet with family, change and recheck status of patient in recovery room. There are several hospital visits and discharge summary, on average 6-15 minutes postoperative visits are needed.

SURVEY DATA:

Specialty: Oral and Maxillofacial Surgery

Sample Size: 66 Response Rate (%): 45 Median RVW: 8.92

25th Percentile RVW: 7.61 75th Percentile RVW: 10.88 Low: 5 High: 15

Median Pre-Service Time: 75 min. Median Intra-Service Time: 120 min.

25th Percentile Intra-Svc Time: 75 75th Percentile Intra-Svc Time: 128 Low: 30 High: 270

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure	<u>42.5</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>52.5</u>	<u>2.5</u>
Office:	<u>87.5</u>	<u>6</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	21032	Excision of maxillary torus palatinus	4.27
2)	21215	Graft, bone; mandible (includes obtaining graft)	10.07
3)	21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	6.04
4)	21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	14.19

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and intensity (mental effort and judgment; technical skill & physical effort; and psychologist stress) of the service you are rating to the key reference services listed above.

21032: Excision of maxillary torus palatinus - is usually performed in the office and requires about 1/2 the pre-intra and post-service times. Intensity is less because less risk.

21215: Graft, bone; mandible (includes obtaining graft) requires the same pre-service and post service time on the day of surgery. Intra-service time is a little less because not taking graft. Intensity is about the same.

21360: Open treatment of depressed malar fracture, including zygomatic arch and malar tripod. Pre-service and post-service on the day of surgery are about the same. Intra-service work time is 1/3 to 1/2. Post-service office visits are 1/5.

21470: Open treatment of complicated mandibular fracture by multiple surgical approaches, including interdental fixation, and/or wiring of dentures or splints.

Pre-service and post-service on the day of surgery are the same. Intra-service time is less because no fixation is necessary. Post-operative hospital visits will be about the same, but post-operative office visit will be greater. The intensity is about the same.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from AMA or your own research.

We believe the increase in relative value is justified because of the nature of treatment for an osteomyelitis. The value for the mandible should not be that much different than other bones. Also, in a vertical evaluation of other oral surgery codes, it is currently undervalued.

Public Comments

30-Jun-95

Code: 21025

1995 RVUs: 5.03

Recommended RVUs: 8.98

Ratio:

Long Descriptor: Excision of bone (eg, for osteomyelitis or bone abscess); mandible

Reference Set (y/n): N Global Period: 090 Frequency: 896 Impact: 3539

Source: 2 Year: 92 Public Comment Letter: 186

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOMS

Societies Wishing to Comment: AAFPRS, AAO-HNS, ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
21025	34.5	3.4	17.2	51.7	13.8	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
21025	935	1010	3.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
21025	32.5	31.7	-0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
21025	general surgery	2.2
	group practices	2.8
	other nonphysician prov	55
	otolaryngology	36.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
21025	141	1.7	MALIGNANT NEOPLASM OF TONGUE
	525	2.6	OTHER DISEASES AND CONDITIONS OF
	526	17.2	DISEASES OF THE JAWS

Public Comments

30-Jun-95

730	1.7	OSTEOMYELITIS, PERIOSTITIS, AND OTH
802	1.7	FRACTURE OF FACE BONES

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
21025							
AAOMS			090		5.03		5.03

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
21025								
AAOMS	5.03	5.03		1.00	1.00	1.00	8.98	186

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
21025								
AAOMS	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
21025									
AAOMS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
21025									
AAOMS				8.98	5.03				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 21031

Global Period: 090 **Current RVW:** 2.01 **Recommended RVW:** 5.30

CPT Descriptor:

Excision of torus mandibularis.

Source and Summary of Comment to HCFA on this service:

Code 21031 is similar to code 21032, (Work RVU-4.27) (excision of maxillary torus palatinus) and is closer to code 21041 (Work RVU-5.03) (Excision of benign cyst or tumor of mandible; complex) and 24120 (Work RVU-6.36) (Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process) in complexity and intra-operative time and should have a relative value in the same RVU range. Source: AAOMS Special Committee on Physician Payment Review Commission.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This procedure is used to recontour a bony exostosis which interferes with placement of a prosthesis to restore function. A patient presents with a unilateral torus mandibularis which impedes placement of a prosthesis. The procedure includes intra oral incision of oral mucosa. A bur and/or chisel is used to remove the exostosis with rasps used to smooth the area. Soft tissue is closed and sutures placed. The complication rate is low with predictable outcomes.

Description of Pre-Service Work:

This is an office procedure 95% of the time. Meeting with family review of consent and surgical procedure.

Description of Intra-Service Work:

Includes a 5-7 cm intraoral incision reflection of mucoperiosteum, use of drills, saws, chisels and rasps to remove and smooth area. Tissue is closed with sutures.

Description of Post-Service Work:

Meeting with family, giving prescriptions, instructions, completing records. The patient usually requires 2 post-op visits.

SURVEY DATA:

Specialty: Oral and Maxillofacial Surgery

Sample Size: 66 Response Rate (%): (45%) 30 Median RVW: 4.13

25th Percentile RVW: 3.58 75th Percentile RVW: 4.48 Low: 3 High: 5

Median Pre-Service Time: 25 min. Median Intra-Service Time: 30 min.

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 44 Low: 15 High: 30

CPT Code: 21031

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure	<u>15</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>0</u>	<u>0</u>
Office:	<u>20</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	21030	Excision of benign tumor or cyst of facial bone other than mandible	7.05
2)	21032	Excision of maxillary torus palatinus	4.27
3)	11441	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	1.56
4)	40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	2.26

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and intensity (mental effort and judgment; technical skill & physical effort; and psychologist stress) of the service you are rating to the key reference services listed above.

21030: Often times is an office procedure for oral surgeons, but may also require hospital care in 30% of the cases. Then, the presurgical and post-service time are increased. A small percentage of cases will be more complex requiring greater intra-operative time. An average post-operative office visit will be about the same.

21032: This is a similar procedure performed on the maxillary bone. The pre-intra and post-service time are very similar.

11441: The pre-service time and immediate post-service time are about the same or slightly less. The intra-operative time is substantially less than removal of a bone lesion.

CPT Code: 21031

40819: The pre-service time and immediate post-service time are about the same or slightly less. The intra-operative time is substantially less than removal of a bone lesion.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from AMA or your own research.

We feel this code is undervalued when compared to other similar oral surgery codes as expressed in the submitted data.

Public Comments

30-Jun-95

Code: 21031

1995 RVUs: 2.01

Recommended RVUs: 5.30

Ratio:

Long Descriptor: Excision of torus mandibularis

Reference Set (y/n): N

Global Period: 090

Frequency: 1,738

Impact: 5718

Source: 2

Year: 92

Public Comment Letter: 186

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOMS

Societies Wishing to Comment: AAFPRS, AAO-HNS, ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
21031	27.5	0	18.4	32.5	0	0	0	13.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
21031	1405	1788	12.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
21031	7.8	6.6	-0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
21031	other nonphysician prov	79.9
	otolaryngology	18.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
21031	523	1.3	GINGIVAL AND PERIODONTAL DISEASE
	525	1.3	OTHER DISEASES AND CONDITIONS OF
	526	22.5	DISEASES OF THE JAWS

Harvard Data:

Public Comments

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
21031							
AAOMS			090		2.01		2.01

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
21031								
AAOMS	2.01	2.01		1.00	1.00	1.00	5.30	186

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
21031								
AAOMS	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	lcuvis	Offvis
21031									
AAOMS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
21031									
AAOMS				5.30	2.01				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 21041

Global Period: 090 **Current RVW:** 5.03 **Recommended RVW:** 7.08

CPT Descriptor:

Excision of benign tumor or cyst of mandible; complex

Source and Summary of Comment to HCFA on this service:

Code 21041, is similar to code 21030 (Work RVU-7.05) (excision of benign tumor or cyst of facial bone other than mandible), in intra-operative time and complexity and in some cases can carry a slightly higher degree of difficulty. This can also be related to orthopedic code 24110 (Work RVU-7.08) (Excision or curettage of bone cyst or benign tumor, humerus). Source: AAOMS Special Committee on Physician Payment Review Commission.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The procedures performed under this code involve removal of pathology of the mandible which has risks of fractures, nerve damage and loss or damage to adjoining teeth. Patient presents with radiographic evidence of Keratocyst or benign tumor greater than 3 cm in size impinging on adjacent structures. The procedure involves an intra oral incision of oral mucosa, reflection of mucoperiosteum, removal of bone for access, removal of cyst/tumor, dissection and preservation of inferior alveolar nerve and preservation of adjacent teeth. The size of the defect requires frequent irrigations and prolonged follow up for secondary healing.

Complications include paresthesia and secondary infection during the secondary healing phase. Mandibular fracture and damage or loss of teeth in the area are dependent on the degree of pathology.

Description of Pre-Service Work:

Review chart - see patient and family, change, in operating room, stabilize endotracheal tube, scrub, and drape.

Description of Intra-Service Work:

An intraoral incision and reflection of mucoperiosteum, removal of bone for access, removal of cyst - dissection of inferior alveolar nerve, dissection to preserve as many teeth as possible, placement of packing or drains, closure of incision.

Description of Post Service Work:

Apply pressure dressing, dictate chart, see family, change, check patient in recovery room. Usually discharged on 1st post-op day, discharge summary and hospital visit. Office follow-up visits include pack, drain, and suture removal, along with 6-8 post-op visit with irrigation while healing.

CPT Code: 21041

SURVEY DATA:

Specialty: Oral and Maxillofacial Surgery

Sample Size: 66 Response Rate (%): (45%) 30 Median RVW: 7.50

25th Percentile RVW: 7.05 75th Percentile RVW: 8.50 Low: 5.87 High: 13.5

Median Pre-Service Time: 60 min. Median Intra-Service Time: 90 min.

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 120 Low: 45 High: 150

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure	<u>30</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>30</u>	<u>1</u>
Office:	<u>75</u>	<u>6</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	21030	Excision of benign tumor or cyst of facial bone other than mandible	7.05
2)	21422	Open treatment of palatal or maxillary fracture (LeFort I type);	7.78
3)	21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints.	14.19
4)	21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	6.04

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and intensity (mental effort and judgment; technical skill & physical effort; and psychologist stress) of the service you are rating to the key reference services listed above.

21030: The pre-service work intra-service and post-service time and intensity are identical except the lesion is in the maxilla rather than the mandible.

21422: Pre-service work may be slightly more do to nature of emergency. Intra-service time is about the same as is the post-service work.

21470: Pre-service work may be slightly more. Intra-service work time is probably 1.5 - 2.0 times. The post-service hospital and office visits are about the same. The intensity may be a little higher.

21360: Pre-service is about the same. Intra-service time may be less and the post-service hospital and office visits are about half.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from AMA or your own research.

Code 21041 in relationship to other oral surgery codes is undervalued as demonstrated in enclosed data survey.

Public Comments

30-Jun-95

Code: 21041

1995 RVUs: 5.03

Recommended RVUs: 7.08

Ratio:

Long Descriptor: Excision of benign cyst or tumor of mandible; complex

Reference Set (y/n): N Global Period: 090 Frequency: 1,053 Impact: 2159

Source: 2 Year: 92 Public Comment Letter: 186

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAOMS

Societies Wishing to Comment: AAFPRS, AAO-HNS, ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
21041	33.3	11.1	5.6	47.2	25	0	0	22.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
21041	1253	1228	-1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
21041	19.7	11.9	-3.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
21041	other nonphysician prov	75.1
	otolaryngology	22.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
21041	213	9.7	BENIGN NEOPLASM OF BONE AND ARTI
	522	2.8	DISEASES OF PULP AND PERIAPICAL TIS
	526	11.8	DISEASES OF THE JAWS
	528	2.1	DISEASES OF THE ORAL SOFT TISSUES, E

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
21041							
AAOMS			090		5.03		5.03

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
21041								
AAOMS	5.03	5.03		1.00	1.00	1.00	7.08	186

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
21041								
AAOMS	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
21041									
AAOMS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
21041									
AAOMS				7.08	5.03				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 30920 Global Period: 090 Current RVW: 7.46 Recommended RVW: 8.79

CPT Descriptor: Ligation arteries: internal maxillary artery, transantral

Source and Summary of Comment to HCFA on this service:

American Academy of Otolaryngology—Head and Neck Surgery

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 75 year old hypertensive that has had uncontrolled nasal bleeding and is anemic. The operation is a microscopic procedure to ligate a major artery behind the paranasal sinuses. The anatomy is highly variable and the difficulty of procedure is high. Complications which may occur are: massive bleeding, complete anesthesia of the cheek, creation of an oral-sinus fistula and blindness.

Description of Pre-Service Work: The patient is encountered typically in the emergency room or after posterior nasal packing has been in place for 24 to 48 hours without successfully controlling the hemorrhage. There is a need for a history and physical examination, review of the patient's hospital course to date, review of the patient's coagulation status and labs, review of the risks and complications of the procedure and discussion with the patient's family and primary care physician.

Due to the emergency nature of this operation, there is typically less time for and orderly preparation of the patient as can be done for an elective procedure. In addition, the patient population consists of elderly individuals with hypertension, COPD and other significant medical problems.

Description of Intra-Service Work: The patient is placed on the operating room table in a supine position. The procedure may be performed under either a local or general anesthetic. In any event, vasoconstrictive solution is injected into the gingivobuccal sulcus and the greater palatine nerves.

The incision is made in the upper gingivobuccal sulcus. The soft tissues of the cheek are elevated from the face of the maxillary sinus. A Caldwell-Luc maxillary antrostomy is performed. The posterior wall of the maxillary sinus is identified and opened. The soft tissues of the pterygomaxillary fossa are identified. The internal maxillary artery and its subordinate branches are identified and hemostatic clips are identified. Other important neural and muscular tissues of the pterygomaxillary fossa are identified and dissected free.

All of this work is performed in close proximity to the orbital apex. There have been reported instances of ligation of the optic nerve or other critical technical errors in the performance of this procedure. All of the work is done via the microscope in a limited area with a hemodynamically fragile patient.

Upon completion of the ligation, the packing in the patient's nasal cavity is removed and the wound is inspected to ensure that the hemorrhage has ceased. An antral window is created and the gingivobuccal sulcus incision closed. The patient is taken to the recovery room.

Description of Post-Service Work: The patient will be followed closely as any other patient who has recently undergone treatment for a bleeding disorder. Serial hematocrit determinations will be required as well as careful monitoring of the patient's ventilatory status. The patient will be examined at least 2 to 3 times per day for 20 to 30 minutes each visit.

The patient will be examined as an outpatient 2 to 3 times at an intermediate (level 99213).

The patient often requires transfusion and treatment of hypertension over the next 24 to 48 hours. In addition, at least two follow up visits are required within the 90 day global period.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery
American Rhinologic Society

Sample Size: 59 Response Rate (%): 54.24 Median RVW: 8.79

25th Percentile RVW: 8.25 75th Percentile RVW: 10.00 Low: 5.50 High: 15.50

Median Pre-Service Time: 60 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 150 Low: 40 High: 360

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>35</u>	
ICU:	<u>35</u>	<u>2</u>
Other Hospital:	<u>45</u>	<u>3</u>
Office:	<u>35</u>	<u>3</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	9.86
31075	Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type).	8.57

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Respondents' choice of reference services varied widely. However, the two listed above each were selected by six physicians. CPT code 30920 and the above-listed reference services are all 90-day global services.

According to the survey results, the pre-, intra, and post-service times of these reference services are very similar to those of 30920. The mental effort, technical skill, and psychological stress also appear to be similar.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The difficulty of this procedure is great, with the possibility of serious complications. Often the procedure is performed as an emergency, which increases the mental effort and technical skill required. The ligation is performed in close proximity to the orbital apex. There have been reported instances of ligation of the optic nerve or other critical technical errors in the performance of this procedure. In addition, the post-operative course can be very complicated.

Public Comments

30-Jun-95

Code: 30920

1995 RVUs: 7.46

Recommended RVUs: 10.00

Ratio:

Long Descriptor: Ligation arteries; internal maxillary artery, transantral

Reference Set (y/n): N

Global Period: 090

Frequency: 477

Impact: 1212

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
30920	22.2	0	22.2	44.4	0	0	0	22.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
30920	557	592	3.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
30920	78.1	78.4	0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
30920	group practices	3.7
	otolaryngology	93.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
30920	280	2.8	IRON DEFICIENCY ANEMIAS
	401	2.8	ESSENTIAL HYPERTENSION
	448	2.8	DISEASE OF CAPILLARIES
	470	2.8	DEVIATED NASAL SEPTUM
	473	2.8	CHRONIC SINUSITIS

Public Comments

30-Jun-95

784	22.2	SYMPTOMS INVOLVING HEAD AND NEC
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
30920							
AAOHNS		090	090	7.53	7.46	0.99	7.46

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
30920								
AAOHNS	7.46	7.46	0.99	1.00	1.00	1.00	10.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
30920								
AAOHNS	090	7.53		27		78		

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
30920									
AAOHNS					2.5		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
30920									
AAOHNS		10		10.00	7.46	ot	3		0.056

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 31225 Global Period: 090 Current RVW: 15.19 Recommended RVW: 18.40

CPT Descriptor: Maxillectomy; without orbital exenteration

Source and Summary of Comment to HCFA on this service: AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 60 year old with squamous cell carcinoma of the maxillary sinus with chronic obstructive pulmonary disease. Need for pre-op internal medical evaluation.

Description of Pre-Service Work: A history and physical examination have been completed previously. The radiographs are reviewed and reports are attached to the patient's chart. Any last minute questions with the family are reviewed. A thorough explanation of the acute and long-term disability from maxillectomy, particularly emphasizing the need for a maxillofacial prosthesis is once again reviewed. Discussion with the anesthesiologist regarding handling of the airway.

Description of Intra-Service Work: The patient is placed on the operating room table in a supine position. The entire face is sterilely prepped and draped. The leg is left out so that a skin graft may be harvested at a later time in the operation.

A Weber-Ferguson incision is made to allow exposure of the cheek. This incision is carried around the gingivo-buccal sulcus to allow exposure of the lateral and posterior aspects of the maxillary complex.

Bony cuts are made at the hard palate, zygomatic arch, nasal bone, ethmoid sinus and pterygoid plates.

The orbital contents are carefully retracted in a delicate fashion to preserve their function postoperatively. This typically requires more work than in a maxillectomy with orbital exenteration. The specimen is delivered and the wound is copiously irrigated and hemostasis obtained.

A frozen section analysis of the margins is obtained. A split thickness skin graft from the leg is obtained (additional code). This skin graft is sutured in place to provide a lining for the maxillofacial prosthesis. The prosthesis is secured in place and packing is positioned to provide support for the skin graft. The wound is closed in layers and the patient is taken to the recovery room.

Particularly and troublesome in this operation is the intense nature of the procedure. The wound is constantly bleeding and there is no way to obtain adequate hemostasis until the specimen has been removed. In addition, the operation of maxillectomy with orbital exenteration is actually more difficult than that of preserving the orbit despite the seemingly more limited surgery.

Description of Post-Service Work: The patient will be seen in the intensive care unit two times per day for the 2 days. The patient is customarily discharged to the floor and remains there for five to seven days. During that time, the patient is again customarily seen twice per day.

SURVEY DATA:Specialty: American Academy of Otolaryngology—Head and Neck SurgerySample Size: 47 Response Rate (%): 66.00 Median RVW: 18.4025th Percentile RVW: 15.63 75th Percentile RVW: 20.75 Low: 15.19 High: 28.00Median Pre-Service Time: 90 Median Intra-Service Time: 18025th Percentile Intra-Svc Time: 135 75th Percentile Intra-Svc Time: 232 Low: 90 High: 420

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>22.5</u>	<u>2</u>
Other Hospital:	<u>80</u>	<u>6</u>
Office:	<u>80</u>	<u>6</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	23.69	090
31360	Laryngectomy; total, without radical neck dissection	15.19	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 31225, which describes a maxillectomy without orbital exenteration was felt to lie within the range of reference services by those physicians responding to the AAO-HNS survey.

The pre service time of our survey of 90 minutes, exceeds that of any of the key reference services according to Harvard data.

The median intra service time of 180 minutes is consistent with the range of intra operative times given by Harvard data for the three reference services.

The post service time is actually greater than that of the Harvard data for the referenced services.

Maxillectomy without orbital exeneration encompasses similar type of work to reference service 21433. There is skeletonization of the facial framework with osteotomies necessary to release the maxilla. There is additional work in preserving the orbit. Most head and neck surgeons that maxillectomy without orbital exeneration, particularly preserving the integrity of the maxilla during its removal, is a harder procedure than maxillectomy with orbital exeneration.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

As stated above, most head and neck surgeons feel that maxillectomy without orbital exeneration is in point of fact a more difficult operation than doing the maxillectomy preserving the orbit. This is due to the fact of the complex relationships of the posterior aspect of the maxilla to the orbit.

The only reason to preserve the orbit is obviously to preserve vision. If in fact, during the removal of the maxilla, the orbit is compromised then the procedure has not been totally successful, even though there may be an adequate oncologic procedure performed.

This difficulty of this procedure was not captured in the initial Harvard survey data, upon which the current work RVU for this procedure has been promulgated. In particular, the increased intra operative work, accompanied with the intensity and number of visits post operatively are underestimated in the current evaluation by HCFA.

Public Comments

30-Jun-95

Code: 31225

1995 RVUs: 15.19

Recommended RVUs: 25.00

Ratio:

Long Descriptor: Maxillectomy; without orbital exenteration

Reference Set (y/n): N

Global Period: 090

Frequency: 665

Impact: 6524

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
31225	55.6	11.1	5.6	61.1	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31225	882	753	-7.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31225	82.2	78.1	-2.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31225	general surgery	7.6
	group practices	4.4
	other nonphysician prov	3.1
	otolaryngology	80.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
31225	143	1.4	MALIGNANT NEOPLASM OF GUM
	145	4.2	MALIGNANT NEOPLASM OF OTHER AND
	147	1.4	MALIGNANT NEOPLASM OF NASOPHAR

Public Comments

30-Jun-95

148	1.4	MALIGNANT NEOPLASM OF HYPOPHAR
160	6.9	MALIGNANT NEOPLASM OF NASAL CAVI
170	2.8	MALIGNANT NEOPLASM OF BONE AND
473	4.2	CHRONIC SINUSITIS
784	2.8	SYMPTOMS INVOLVING HEAD AND NEC

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31225							
AAOHNS		090	090	14.63	15.19	1.04	15.19

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31225								
AAOHNS	15.19	15.19	1.04	1.00	1.00	1.00	25.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
31225								
AAOHNS	090	14.63		29		172		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31225									
AAOHNS		1.0		15	5.0		10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
31225									
AAOHNS		15		25.00	15.19	ot	3		0.052

Public Comments

30-Jun-95

Code: 31230

1995 RVUs: 21.06

Recommended RVUs: 30.00

Ratio:

Long Descriptor: Maxillectomy, with orbital exenteration (en bloc)

Reference Set (y/n): N

Global Period: 090

Frequency: 97

Impact: 867

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
31230	0	0		0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31230	103	127	11.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31230	84.4	60.5	-11.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31230	general surgery	3.2
	group practices	4.7
	internal medicine	3.2
	otolaryngology	81.8
	plastic surgery	3.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
31230	170	25	MALIGNANT NEOPLASM OF BONE AND
	190	25	MALIGNANT NEOPLASM OF EYE

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31230							
AAOHNS		090	090	21.34	21.06	0.99	21.06

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31230								
AAOHNS	21.06	21.06	0.99	1.00	1.00	1.00	30.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
31230								
AAOHNS	090	21.34		41		237		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31230									
AAOHNS		1.0		15	10.0		15	0.0	5.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
31230									
AAOHNS		15		30.00	21.06	ot	3		0.050

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 31290 Global Period: 010 Current RVW: 12.87 Recommended RVW: 16.05

CPT Descriptor: Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region

Source and Summary of Comment to HCFA on this service:

American Academy of Otolaryngology—Head and Neck Surgery
American Rhinologic Society

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient presents with a history of head trauma and clear rhinorrhea. The rhinorrhea is unilateral and there is no history of allergy. Nasal endoscopy reveals unilateral clear rhinorrhea, but no definite site of origin is present. There is a large polyp on the same side. CT demonstrates that the ethmoid roof is displaced inferiorly on the side of the rhinorrhea and there is an associated intranasal mass. No definite leak is demonstrated with intrathecal contrast CT. MRI suggests there is a frontal lobe prolapse into the mass. The rhinorrhea is positive for B2 transferrin.

Description of Pre-Service Work: The patient's records and imaging studies (including angiogram when needed) are carefully evaluated to determine the best approach. The relative risks are discussed with the patient. The patient is re-endoscoped at the time of pre-admission evaluation to rule out intercurrent infection. The pre-anesthesia studies are reviewed and an admission note written. After the induction of general anesthesia, the patient is positioned and prepped for lumbar puncture. A spinal drain is placed, and intrathecal dye mixed with the patient's CSF is injected slowly over 5 minutes. The patient is then re-positioned and the face prepped and draped. The nasal mucosa is decongested by the application of topical decongestants.

Description of Intra-Service Work: A complete endoscopic ethmoidectomy (31255) and frontal sinusotomy (31276) is performed. Sphenoidotomy with removal of tissue (31288) is frequently required to expose additional skull base. A maxillary antrostomy (31267) may or may not be required for orientation and post-operative drainage. The skull base is carefully skeletonized and exposed. The middle or superior turbinate is frequently resected (30130). The meningo-encephalocele is approached and the defect localized. The protruding brain and dura is sequentially bipolar cauterized and resected in stages. The patient is carefully monitored during the resection. Attention is then directed towards the opposite nasal septum and a mucoperichondrial graft harvested under endoscopic visualization (20912). A bone graft may also be required. Additionally, a large defect will require that fascia be harvested from an additional site (temporalis) (20926). The bone graft is then fashioned to fit the defect, placed intracranially through the defect and secured in place. The mucoperichondrial graft is secured in place with micro-fibrillar collagen and packed into place with gelfoam and sponges. The donor site is covered with microfibrillar collagen and packed.

Description of Post-Service Work: The patient requires post-surgical visits on the night of surgery, 2x/day in the early post-operative period and once a day thereafter for a total hospitalization of 5-7 days. Neurological checks are performed for 12-24 hrs, the patient is maintained on I.V. antibiotics and monitored for meningitis. The spinal drain is left in place for 72 hrs and the patient remains on complete bed rest for four days. Packing is removed from one side of the nose the day following surgery. The sponges and some absorbable packing are removed from the second side of the nose prior to discharge. At this time the nose is carefully cleaned.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery
American Rhinologic Society

Sample Size: 33 Response Rate (%): 84.85 Median RVW: 16.05

25th Percentile RVW: 14.88 75th Percentile RVW: 20.25 Low: 11.00 High: 27.91

Median Pre-Service Time: 120 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 150 75th Percentile Intra-Svc Time: 210 Low: 75 High: 360

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>30</u>	<u>2</u>
Other Hospital:	<u>60</u>	<u>4</u>
Office:	<u>30</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
62100	Craniotomy for repair of dural/CSF leak, including surgery for rhinorrhea/otorrhea.	20.78
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior).	6.96

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill

& physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Over one-third of the respondents used the craniotomy as a reference service. Regarding pre-service work, the evaluation of imaging studies and patient discussion is similar to the craniotomy. However, the extracranial approach requires additional nasal evaluation for deformities which may present intra-operative problems and, on the day prior to surgery, to exclude the presence of intercurrent infection. Similarly, placement of a lumbar drain is typically performed for this repair, but is not performed in the craniotomy. However, the intranasal approach does not require partial head shaving as is required with craniotomy. Overall, pre-service work time is greater with 31290 than with 62100.

In comparison to craniotomy, the overall intensity of 31290 is higher because there is no opening or closing time. The entire approach is performed in close proximity to the skull base and the orbit and must be performed with great care. Trauma to surrounding structures must be avoided at all costs.

Repair of CSF leak has a 10-day global period and the craniotomy carries a 90-day global period, but most of the post-operative care for the craniotomy occurs within the first 10 days.

The component parts of the repair of CSF leak include an endoscopic total ethmoidectomy (31255), frontal sinusotomy (31276) and frequently include endoscopic sphenoidectomy with removal of mucosa (31288), turbinate resection (30130), and maxillary antrostomy (31267). A mucosal graft is always harvested (20912), a bone graft is often required and a temporalis fascial graft (20926) may be required.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

We received an 84.85% response rate on the survey for this code. However, the number of respondents do not number 30, because the sample size was so small. This procedure is performed by only a small number of physicians across the country. This is evidenced by the small number of this procedure billed to Medicare for 1994 -- 36. We believe that the number of respondents is sufficient to base a valid recommendation.

Two-thirds of the respondents believe that the work required for the repair of the CSF leak has changed over the last five years. Over half of the respondents believe that the patients are more complex (none believe that the patients are less complex and three believe that there has been no change). The RUC previously recommended a work RVU of 18.33 (adjusted for 1995) for 31290. However, HCFA arbitrarily significantly reduced that recommendation based on a faulty crosswalk between old and new codes for functional endoscopic sinus surgery.

Public Comments

30-Jun-95

Code: 31290

1995 RVUs: 12.87

Recommended RVUs: 30.00

Ratio:

Long Descriptor: Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region

Reference Set (y/n): N Global Period: 010 Frequency: 32 Impact: 548

Source: 10 Year: 94 Public Comment Letter: 338

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31290	.	36	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31290	.	61.1	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31290	neurological surgery	5.6
	otolaryngology	94.4

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31290							
	AAOHNS		010	.	12.87	.	.
	ARS		010	.	12.87	.	.

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31290								
AAOHNS	.	12.87	.	.	.	1.00	30.00	338
ARS	.	12.87	.	.	.	1.00	24.36	302

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
31290								
AAOHNS	010	.	.	.	.	.	.	.
ARS	010	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31290									
AAOHNS
ARS

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
31290									
AAOHNS	.	.	.	30.00	12.87	.	.	.	.
ARS	.	.	.	24.36	12.87	.	.	.	.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 31291 Global Period: 010 Current RVW: 13.52 Recommended RVW: 17.00

CPT Descriptor: Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid region: sphenoid region

Source and Summary of Comment to HCFA on this service:

American Academy of Otolaryngology—Head and Neck Surgery
American Rhinologic Society

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient presents with a history of recurrent meningitis and bilateral clear rhinorrhea. Diagnostic evaluations including CT, MRI, and possibly angiogram reveal a bony erosion of the lateral wall of the sphenoid sinus and an associate intra-sinus mass. Careful evaluation has failed to provide any other likely cause for rhinorrhea or recurrent meningitis.

Description of Pre-Service Work: The patient's records and imaging studies are carefully evaluated to determine the best approach. An angiogram is performed and reviewed to exclude any significant intralesional blood vessels. The relative risks are considered and discussed with the patient. The patient is re-endoscoped at the time of pre-admission evaluation to rule out intercurrent infection. The pre-anesthesia studies are reviewed and an admission note written. After the induction of general anesthesia, the patient is positioned and prepped for lumbar puncture. A spinal drain is placed, and intrathecal dye mixed with the patient's CSF is injected slowly over 5 minutes. The patient is then re-positioned and the face prepped and draped. The nasal mucosa is decongested by the application of topical decongestants.

Description of Intra-Service Work: A complete endoscopic ethmoidectomy (31255) and sphenoidotomy with removal of tissue (31288) is performed. A maxillary antrostomy (31267) frequently may be required for orientation and post-operative drainage or a frontal sinusotomy (31276) to allow inspection of the entire ethmoid roof. The skull base is carefully skeletonized and exposed. The superior turbinate is resected (30130). Mucosa is removed from the sphenoid sinus. The meningo-encephalocele is approached and the defect localized. The protruding brain and dura is sequentially bipolar cauterized and resected in stages. The patient is carefully monitored during the resection. Attention is then directed towards the opposite nasal septum and a mucoperichondrial graft harvested under endoscopic visualization (20912). A bone graft is also harvested. Fascia may or may not be also harvested and placed as a first layer closure (20926). The bone graft is then fashioned to fit the defect, placed intracranially through the defect and secured in place. The mucoperichondrial graft is secured in place with micro-fibrillar collagen and packed into place with gelfoam and sponges. The donor site is covered with microfibrillar collagen and packed.

Description of Post-Service Work: The patient requires post-surgical visits on the night of surgery, 2x/day in the early post-operative period and once a day thereafter for a total hospitalization of 5-7 days. Neurological checks are performed for 12-24hrs, the patient is maintained on I.V. antibiotics and monitored for meningitis. The spinal drain is left in place for 72hrs and the patient remains on complete bed rest for four days. Packing is removed from one side of the nose the day following surgery. The sponges and some absorbable packing are removed from the second side of the nose prior to discharge. At this time the nose is carefully cleaned.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery
American Rhinologic Society

Sample Size: 32 Response Rate (%): 68.75 Median RVW: 17.00

25th Percentile RVW: 15.00 75th Percentile RVW: 20.00 Low: 13.95 High: 28.60

Median Pre-Service Time: 120 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 150 75th Percentile Intra-Svc Time: 240 Low: 105 High: 360

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>48</u>	
ICU:	<u>30</u>	<u>2</u>
Other Hospital:	<u>60</u>	<u>4</u>
Office:	<u>30</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
62100	Craniotomy for repair of dural/CSF leak, including surgery for rhinorrhea/otorrhea.	20.78
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.4

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Regarding pre-service work, the evaluation of imaging studies and patient discussion is similar to the craniotomy. However, the extracranial approach requires additional nasal evaluation for deformities which may present intra-operative problems and, on the day prior to surgery, to exclude the presence of intercurrent infection. Similarly, placement of a lumbar drain is typically performed for this repair, but is not performed in the craniotomy. However, the intranasal approach does not require partial head shaving as is required with craniotomy. Overall, pre-service work time is greater with 31291 than with 62100.

In comparison to craniotomy, the overall intensity of 31291 is higher because there is no opening or closing time. The entire approach is performed in close proximity to the skull base and the orbit and must be performed with great care. Trauma to surrounding structures must be avoided at all costs.

Repair of CSF leak has a 10-day global period and the craniotomy carries a 90-day global period, but most of the post-operative care for the craniotomy occurs within the first 10 days.

The component parts of the repair of CSF leak include an endoscopic total ethmoidectomy (31255), endoscopic sphenoidectomy with removal of mucosa (31288), turbinate resection (30130), and typically would include either frontal sinusotomy (31276) or maxillary antrostomy (31267). A mucosal graft is always harvested (20912), a bone graft is often required and a temporalis fascial graft (20926) may be required.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Over half of the respondents believe that the work required for the repair of the CSF leak has changed over the last five years. All of those who answered the question believe that the patients are more complex. The RUC previously recommended a work RVU of 19.31 (adjusted for 1995) for 31291. However, HCFA arbitrarily significantly reduced that recommendation based on a faulty crosswalk between old and new codes for functional endoscopic sinus surgery.

We received an 68.75% response rate on the survey for this code. However, the number of respondents do not number 30, because the sample size was so small. This procedure is performed by only a small number of physicians across the country. This is evidenced by the small number of this procedure billed to Medicare for 1994 -- 38. We believe that the number of respondents is sufficient to base a valid recommendation.

Public Comments

30-Jun-95

Code: 31291

1995 RVUs: 13.52

Recommended RVUs: 30.00

Ratio:

Long Descriptor: Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region

Reference Set (y/n): N

Global Period: 010

Frequency: 24

Impact: 396

Source: 10

Year: 94

Public Comment Letter: 338

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31291	.	38	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31291	.	68.4	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31291	group practices	10.5
	internal medicine	5.3
	otolaryngology	84.2

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31291							
	AAOHNS		010	.	13.52	.	.

Public Comments

30-Jun-95

ARS	010	13.52
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31291								
AAOHNS	.	13.52	.	.	.	1.00	30.00	338
ARS	.	13.52	.	.	.	1.00	26.32	302

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
31291								
AAOHNS	010	.	.	.	.	.	.	.
ARS	010	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31291									
AAOHNS
ARS

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
31291									
AAOHNS	.	.	.	30.00	13.52	.	.	.	.
ARS	.	.	.	26.32	13.52	.	.	.	.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 31292 Global Period: 010 Current RVW: 10.45 Recommended RVW: 13.83

CPT Descriptor: Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression

Source and Summary of Comment to HCFA on this service:

AAO-HNS
ARS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient presents with mild to moderate dysthyroid orbitopathy but with a significant recent visual deterioration and evidence of orbital apex compression. Ophthalmic examination confirms decreased visual acuity and color vision. CT demonstrates the typical changes of thyroid eye disease.

Description of Pre-Service Work: The patient's records and imaging studies are carefully evaluated to determine the best approach, based upon the anatomic findings present and the disease present. The surgical options are discussed along with their respective advantages and disadvantages in that particular patient. The patient is re-endoscoped at the time of pre-admission evaluation to rule out intercurrent infection. The pre-anesthesia studies are reviewed and an admission note written. After the induction of general anesthesia, the patient is prepped and draped. Topical and local anesthesia are applied.

Description of Intra-Service Work: A complete endoscopic ethmoidectomy (31255) and frontal sinusotomy (31276) is performed. Sphenoidotomy with removal of tissue (31288) is required to expose the orbital apex. Maxillary antrostomy (31267) is required for post-operative drainage. The skull base is carefully skeletonized and exposed. The middle turbinate may be resected (30130). The medial orbital wall is exposed throughout and then carefully removed. The underlying periosteum is incised with sequential linear incisions allowing protrusion of the orbital fat.

Description of Post-Service Work: The patient requires post-surgical visits on the night of surgery, daily in the post-operative period. Visual checks are performed for 12-24hrs. If packing is placed, it is removed on the day following surgery. Two endoscopic debridements (31237) are typically performed in the 10 day global period.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery
American Rhinologic Society

Sample Size: 32 Response Rate (%): 71.88 Median RVW: 13.83

25th Percentile RVW: 11.63 75th Percentile RVW: 15.38 Low: 9.50 High: 23.00

Median Pre-Service Time: 90 Median Intra-Service Time: 140

25th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 170 Low: 60 High: 300

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>35</u>	<u>2</u>
Other Hospital:	<u>40</u>	<u>2</u>
Office:	<u>30</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior).	6.96
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction.	16.37
42415	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve.	16.12
67570	Optic nerve decompression (eg, incision or fenestration of optic nerve sheath).	12.52
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	12.41

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Reference services selected by the respondents varied widely, with no one reference service standing out from the crowd. Several respondents did select each of the above-mentioned services. The interpretation of diagnostic studies, informed consent, and preoperative patient evaluation is clearly significantly more complicated for 31292 than for endoscopic sinus surgery for chronic sinusitis (31255, 31276, 31267).

The overall intensity of 31292 also is significantly higher than for endoscopic sinus surgery for chronic sinusitis. Moreover, the procedure includes a total ethmoidectomy (31255), frontal sinusotomy (31276), endoscopic sphenoidectomy (31287), and maxillary antrostomy (31267). Turbinate resection (30130) is frequently required.

31292 carries a 10-day global period and requires significant hospitalization and the patients need to be carefully monitored.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Almost two-thirds of the respondents believe that the work required for 31292 has changed over the last five years. Ten believe that the patients are more complex (none believe the patients are less complex and two believe there has been no change). The RUC previously recommended a work RVU of 15.27 (adjusted for 1995) for 31292. However, HCFA arbitrarily significantly reduced that recommendation based on a faulty crosswalk between old and new codes for functional endoscopic sinus surgery.

We received an 71.88% response rate on the survey for this code. However, the number of respondents do not number 30, because the sample size was so small. This procedure is performed by only a small number of physicians across the country. This is evidenced by the small number of this procedure billed to Medicare for 1994 -- 32. We believe that the number of respondents is sufficient to base a valid recommendation.

Public Comments

30-Jun-95

Code: 31292

1995 RVUs: 10.45

Recommended RVUs: 15.00

Ratio:

Long Descriptor: Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression

Reference Set (y/n): N Global Period: 010 Frequency: 19 Impact: 86

Source: 10 Year: 94 Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31292	.	32	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31292	.	31.3	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31292	otolaryngology	93.8
	plastic surgery	6.3

Claims-Level Diagnosis Information:

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31292	AAOHNS			010	.	10.45	.	.
	ARS			010	.	10.45	.	.

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31292								
AAOHNS	.	10.45	.	.	.	1.00	15.00	338
ARS	.	10.45	.	.	.	1.00	13.54	302

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
31292								
AAOHNS	010	.	.	.	.	.	.	.
ARS	010	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31292									
AAOHNS
ARS

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
31292									
AAOHNS	.	.	.	15.00	10.45	.	.	.	.
ARS	.	.	.	13.54	10.45	.	.	.	.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 31293 Global Period: 010 Current RVW: 11.43 Recommended RVW: 15.15

CPT Descriptor: Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression

Source and Summary of Comment to HCFA on this service:

American Academy of Otolaryngology—Head and Neck Surgery
American Rhinologic Society

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient presents with severe dysthyroid orbitopathy, exposure keratitis, and diplopia and some recent visual deterioration. CT demonstrates the typical changes of severe thyroid eye disease.

Description of Pre-Service Work: The patient's records and imaging studies are carefully evaluated to determine the best approach, based upon the anatomic findings present and the disease present. In particular, the thickness of the medial and inferior orbital wall, the relationship of the orbital apex to the ethmoid/sphenoid sinuses and the presence of intercurrent chronic sinus disease are evaluated. The patient is re-endoscoped at the time of pre-admission evaluation to rule out intercurrent infection. The pre-anesthesia studies are review and an admission note written. After induction of general anesthesia, the patient is prepped and draped.

Description of Intra-Service Work: A complete endoscopic ethmoidectomy (31255) and frontal sinusotomy (31276) is performed. Sphenoidotomy with removal of tissue (31288) is required to expose the orbital apex. A very extensive maxillary antrostomy (31267) is required. In fact most of the medial wall of the maxillary sinus must be removed to provide access to the orbital floor and for post-operative drainage. The skull base is carefully skeletonized and exposed. The middle turbinate may be resected (30130). The medial orbital wall is exposed throughout. The medial orbital wall and the floor of the orbit is then carefully removed. The latter requires working with highly angled instruments and telescopes through the maxillary antrostomy and is technically demanding. The underlying periosteum is incised with sequential linear incisions allowing protrusion of the orbital fat.

Description of Post-Service Work: The patient requires post-surgical visits on the night of surgery, daily in the post-operative period. Visual checks are performed for 12-24hrs. If packing is placed, it is removed on the day following surgery. Two endoscopic debridements (31237) are typically performed in the 10 day global period.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery
American Rhinologic Society

Sample Size: 32 Response Rate (%): 65.63 Median RVW: 15.15

25th Percentile RVW: 12.70 75th Percentile RVW: 16.25 Low: 11.00 High: 24.00

Median Pre-Service Time: 90 Median Intra-Service Time: 18025th Percentile Intra-Svc Time: 145 75th Percentile Intra-Svc Time: 200 Low: 90 High: 360

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>35</u>	<u>2</u>
Other Hospital:	<u>40</u>	<u>3</u>
Office:	<u>30</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior).	6.96
42415	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve.	16.12
67570	Optic nerve decompression (eg, incision or fenestration of optic nerve sheath).	12.52
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	12.41

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Reference services selected by the respondents varied widely, with no one reference service standing out from the crowd. Several respondents did select each of the above-mentioned services. The interpretation of diagnostic studies, informed consent, and preoperative patient evaluation is clearly significantly more complicated for 31293 than for endoscopic sinus surgery for chronic sinusitis (31255, 31276, 31267).

The overall intensity of 31293 also is significantly higher than for endoscopic sinus surgery for chronic sinusitis. Moreover, the procedure includes a total ethmoidectomy (31255), frontal sinusotomy (31276), endoscopic sphenoidectomy (31287), and maxillary antrostomy (31267). Turbinate resection (30130) is frequently required.

31293 carries a 10-day global period and requires significant hospitalization and the patients need to be carefully monitored.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Over half of the respondents believe that the work required for 31293 has changed over the last five years. Ten believe that the patients are more complex (none believe the patients are less complex and one believes there has been no change). The RUC previously recommended a work RVU of 16.73 (adjusted for 1995) for 31293. However, HCFA arbitrarily significantly reduced that recommendation based on a faulty crosswalk between old and new codes for functional endoscopic sinus surgery.

We received an 65.63% response rate on the survey for this code. However, the number of respondents do not number 30, because the sample size was so small. This procedure is performed by only a small number of physicians across the country. This is evidenced by the small number of this procedure billed to Medicare for 1994 -- 10. We believe that the number of respondents is sufficient to base a valid recommendation.

Public Comments

30-Jun-95

Code: 31293

1995 RVUs: 11.43

Recommended RVUs: 15.14

Ratio:

Long Descriptor: Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression

Reference Set (y/n): N

Global Period: 010

Frequency: 6

Impact: 22

Source: 10

Year: 94

Public Comment Letter: 302

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31293	.	10	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31293	.	0	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31293	otolaryngology	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packthv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31293							
	AAOHNS		010	.	11.43	.	.
	ARS		010	.	11.43	.	.

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31293								
AAOHNS	.	11.43	.	.	.	1.00	18.00	338
ARS	.	11.43	.	.	.	1.00	15.14	302

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
31293								
AAOHNS	010	.	.	.	.	.	.	.
ARS	010	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31293									
AAOHNS
ARS

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
31293									
AAOHNS	.	.		18.00	11.43				
ARS	.	.		15.14	11.43				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 31294 Global Period: 010 Current RVW: 13.06 Recommended RVW: 18.00

CPT Descriptor: Nasal/endoscopy, surgical; with optic nerve decompression

Source and Summary of Comment to HCFA on this service:

American Academy of Otolaryngology—Head and Neck Surgery
American Rhinologic Society

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient presents with a history of head trauma. On admission the patient was noted to have unilateral absent pupillary response and CT demonstrated a skull base fracture in the region of the optic canal. The patient has been on massive doses of IV steroids without response and, as the patient is beginning to regain consciousness, there is no vision in the affected eye.

Description of Pre-Service Work: The patient's records and imaging studies are carefully evaluated to determine the best approach, based upon the anatomic findings and fractures present. In particular, the relationship of the orbital apex and optic nerve to the ethmoid/sphenoid sinuses and the presence of intercurrent chronic sinus disease are evaluated. MRI & MRA are reviewed to evaluate for a hematoma in the area of the optic nerve and evaluate the ipsilateral carotid artery. Angiography may be required. Questions are answered. Nasal endoscopy may be required to examine the anatomy and to rule out intercurrent infection. The pre-anesthesia studies are reviewed and a note written. After the induction of general anesthesia, the patient is prepped, draped, and topical and local anesthesia are applied.

Description of Intra-Service Work: A complete endoscopic ethmoidectomy (31255) sinusotomy (31276) is performed. Sphenoidotomy with removal of tissue (31288) is required to expose the orbital apex. A maxillary antrostomy (31267) is typically required for orientation and postoperative drainage. The skull base is carefully skeletonized and exposed. The middle turbinate may be resected (30130). The medial orbital wall is exposed throughout. The medial orbital wall adjacent to the orbital apex is then carefully removed. Using a special drill, irrigation and intermittent suction the bone over the optic nerve is slowly thinned. Great care and skill is required not to injure the adjacent skull base or carotid artery. After the bone has been sufficiently "egg shelled", delicate otologic instruments are used to carefully remove the remaining bone. The nerve sheath is then gently incised. A small CSF leak may be encountered at this stage and, in these cases a mucosal graft is harvested from the opposite side of the nose and placed over the nerve.

Description of Post-Service Work: The patient requires post-surgical visits on the night of surgery, twice daily in the for the first 2-3 days and daily thereafter. Visual checks are performed for 12-24hrs. If packing is placed, it may be removed on the day following surgery. One endoscopic debridement (31237) is typically performed in the 10 day global period.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery
American Rhinologic Society

Sample Size: 31 Response Rate (%): 61.29 Median RVW: 18.00

25th Percentile RVW: 15.38 75th Percentile RVW: 20.00 Low: 13.00 High: 28.50

Median Pre-Service Time: 100 Median Intra-Service Time: 210

25th Percentile Intra-Svc Time: 180 75th Percentile Intra-Svc Time: 240 Low: 90 High: 420

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>40</u>	<u>2</u>
Other Hospital:	<u>45</u>	<u>3</u>
Office:	<u>30</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
67570	Optic nerve decompression (eg, incision or fenestration of optic nerve sheath).	12.52	

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Reference services selected by the respondents varied widely, with a number of reference services receiving one or two votes. The above-mentioned services were the only ones that received more than two votes. The interpretation of diagnostic studies, informed consent, and preoperative patient evaluation is clearly significantly more complicated for 31294 than for endoscopic sinus surgery for chronic sinusitis (31255, 31276, 31267).

The overall intensity of 31294 also is dramatically higher than for endoscopic sinus surgery for chronic sinusitis. Moreover, the procedure includes a total ethmoidectomy (31255), endoscopic sphenoidectomy

(31287), and maxillary anrostomy (31267). Turbinate resection (30130) is frequently required. In addition to the components for the approach and the closure, a very delicate and difficult cranial nerve decompression (67570) must be performed and a mucosal graft may be required.

31294 carries a 10-day global period and requires significant hospitalization and the patients need to be monitored extremely closely. Decompression of the optic nerve (67570) carries a 90-day global period, but most of the postoperative care occurs within the first 10 days.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Over half of the respondents believe that the work required for 31294 has changed over the last five years. Eight believe that the patients are more complex (none believe the patients are less complex and two believe there has been no change). The RUC previously recommended a work RVU of 15.62 (adjusted for 1995) for 31294. However, HCFA arbitrarily significantly reduced that recommendation based on a faulty crosswalk between old and new codes for functional endoscopic sinus surgery.

We received an 61.29% response rate on the survey for this code. However, the numer of respondents do not number 30, because the sample size was so small. This procedure is performed by only a small number of physicians across the cuntry. This is evidenced by the small number of this procedure billed to Medicare for 1994 -- 8. We believe that the number of respondents is sufficient to base a valid recommendation.

Public Comments

30-Jun-95

Code: 31294

1995 RVUs: 13.06

Recommended RVUs: 22.50

Ratio:

Long Descriptor: Nasal/sinus endoscopy, surgical; with optic nerve decompression

Reference Set (y/n): N

Global Period: 010

Frequency: 8

Impact: 76

Source: 10

Year: 94

Public Comment Letter: 338

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31294	.	8	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31294	.	75	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31294	otolaryngology	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31294							
	AAOHNS		010	.	13.06	.	.
	ARS		010	.	13.06	.	.

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31294								
AAOHNS	.	13.06	.	.	.	1.00	22.50	338
ARS	.	13.06	.	.	.	1.00	20.33	302

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
31294								
AAOHNS	010	.	.	.	.	.	.	.
ARS	010	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
31294									
AAOHNS
ARS

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
31294									
AAOHNS	.	.	.	22.50	13.06	.	.	.	.
ARS	.	.	.	20.33	13.06	.	.	.	.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 31390 Global Period: 090 Current RVW: 21.15 Recommended RVW: 25.00

CPT Descriptor: Pharyngolaryngectomy, with radical neck dissection; without reconstruction

Source and Summary of Comment to HCFA on this service: AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 60 year old male with recent weight loss (10-20 #), moderate to severe throat pain, inability to swallow solids, difficulty with speech and breathing. Heavy smoker, moderate to heavy alcohol use. COPD, coronary artery disease, often with poor family support and inadequate coping skills; frequently has had prior radiation and/or chemotherapy.

Examination reveals a bulky tumor infiltrating and partially obstructing the larynx with potential airway obstruction and one or more cervical lymph nodes (3 cm or larger).

Description of Pre-Service Work:

1. record review/visit with patient and family
2. scrub/attend intubation
position/prep/drape
3. laryngoscopy, diagnostic

Description of Intra-Service Work:

1. scrub/prep/tracheotomy, local anesthesia
2. laryngoscopy, diagnostic
3. radical neck dissection
4. laryngopharyngectomy
5. thyroidectomy parathyroid autotransplantation
6. wound closure

Description of Post-Service Work:

1. Dictate op report/write orders; attend transfer to recovery room; visit family; visit ICU same day.
 2. POD # 1-3 - visit ICU
 3. POD # 4-7
 4. POD # 8 - arrange discharge plan
 5. POD # 9-14 - visit on ward
 6. POD #15-24 - outpatient visits
 7. POD #25-90 - outpatient visits
-

SURVEY DATA:Specialty: American Academy of Otolaryngology—Head and Neck SurgerySample Size: 48 Response Rate (%): 63.00 Median RVW: 25.0025th Percentile RVW: 21.15 75th Percentile RVW: 32.00 Low: 16.00 High: 37.43Median Pre-Service Time: 90 Median Intra-Service Time: 30025th Percentile Intra-Svc Time: 240 75th Percentile Intra-Svc Time: 300 Low: 140 High: 600

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>45</u>	<u>3</u>
Other Hospital:	<u>145</u>	<u>10</u>
Office:	<u>90</u>	<u>6</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
31360	Laryngectomy; total, without radical neck dissection	15.19	090
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 31390 was felt to encompass more work than either of the reference services; however, both of the reference services are similar major head and neck procedures.

Survey data from the AAO-HNS instrument demonstrates that the pre service time, intra service time and post service time are all greater than that of the Harvard data for the two key reference services.

Laryngopharyngectomy with radical neck dissection is an extensive head and neck surgical procedure similar to the scope of CPT Code 31365 laryngectomy with neck dissection, but having more work due entrance into the pharynx and removal of adjacent structures. This extra work is not realized in the current valuation for CPT Code 31390.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The extra work involved in performing a pharyngeal resection in addition to a total laryngectomy and neck dissection, has not been captured in the current valuation of CPT Code 31390. As indicated above, the current value for CPT Code 31365, which is a similar procedure, but lacking the pharyngeal component, is 21.83. This small difference in RVU does not explain the extra work, mental stress and effort required to perform the procedure under question. The AAO-HNS survey of physicians performing this work frequently better captures the relationship between these two procedures and the extra work involved in performing a pharyngolaryngectomy.

Public Comments

30-Jun-95

Code: 31390

1995 RVUs: 21.15

Recommended RVUs: 40.00

Ratio:

Long Descriptor: Pharyngolaryngectomy, with radical neck dissection; without reconstruction

Reference Set (y/n): N

Global Period: 090

Frequency: 132

Impact: 2488

Source: 2

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
31390	33.3	0	0	66.7	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31390	123	137	5.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31390	89.4	92.7	1.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31390	general surgery	14.6
	group practices	2.9
	otolaryngology	81

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
31390	148	8.3	MALIGNANT NEOPLASM OF HYPOPHAR
	161	16.7	MALIGNANT NEOPLASM OF LARYNX
	198	16.7	SECONDARY MALIGNANT NEOPLASM O

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31390							
AAOHNS		090	090	25.22	21.15	0.84	21.15

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31390								
AAOHNS	21.15	21.15	0.84	1.00	1.00	1.00	40.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
31390								
AAOHNS	090	25.22		36	*	260		50

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31390									
AAOHNS	*	1.0		10	14.0	*	10	1.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
31390									
AAOHNS	*	15		40.00	21.15	ot	3		0.057

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 31395 Global Period: 090 Current RVW: 26.19 Recommended RVW: 28.00

CPT Descriptor: Pharyngolaryngectomy, with radical neck dissection; with reconstruction

Source and Summary of Comment to HCFA on this service: AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 60 year old male with recent weight loss (10-20 lbs), moderate to severe throat pain, inability to swallow solids, difficulty with speech and breathing. Heavy smoker, moderate to heavy alcohol use, COPD, coronary artery disease, often with poor family support and inadequate coping skills: frequently has had prior radiation and/or chemotherapy.

Examination reveals a bulky tumor infiltrating and partially obstructing the larynx with imminent airway obstruction and one or more cervical lymph nodes (3 cm or larger). Tumor extensively invades inferior pharyngeal wall and esophageal inlet. Surgical excision requires thyroidectomy, postoperative problems may include hypoparathyroidism.

Description of Pre-Service Work:

1. record review/visit with pt and family
2. scrub/attend intubation
position/prep/drape
3. laryngoscopy, diagnostic

Description of Intra-Service Work:

1. Radical neck dissection
2. Laryngopharyngectomy with primary mucosal closure

Description of Post-Service Work:

1. Dictate op/rept/write orders; attend transfer to rec rm; visit family; visit ICU (same day)
2. POD #1 - visit ICU arrange transfer to ward; visit on ward
3. POD #2-7 - visit on ward
4. POD #8 - arrange discharge plan
5. POD #9 - 14 visit on ward
6. POD #15 - 24 outpatient visits
7. POD #25 -90 outpatient visits

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery

Sample Size: 47 Response Rate (%): 66.00 Median RVW: 28.00

25th Percentile RVW: 25.00 75th Percentile RVW: 40.00 Low: 21.00 High: 68.44

Median Pre-Service Time: 100 Median Intra-Service Time: 450

25th Percentile Intra-Svc Time: 380 75th Percentile Intra-Svc Time: 510 Low: 240 High: 900

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>60</u>	
ICU:	<u>60</u>	<u>4</u>
Other Hospital:	<u>170</u>	<u>11</u>
Office:	<u>120</u>	<u>7.5</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
31360	Laryngectomy; total, without radical neck dissection	15.19	090
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	23.69	090
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 31395 describing pharyngolaryngectomy with neck dissection and reconstruction was felt to be valued greater than any of the key references by the respondents to the AAO-HNS survey. The survey pre service, intra service and post service times are all significantly greater than any of the Harvard data for the key reference services. On the other hand, all of the key reference services described major head and neck procedures.

CPT Code 31395 describes one of the most extensive head and neck surgical procedures performed. Of particular concern is the fact that there is undervaluation of the role of reconstruction in this procedure. Particularly concerning is the undervaluation of the post service work, which can be significant in this operation.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT Code 31395 describes an extensive head and neck procedure with removal of the neck contents on one side, the larynx and a major portion of the pharynx. This leaves a considerable void which must be

reconstructed by a secondary technique. The additional valuation afforded to this procedure over its counterpart CPT Code 31390, which describes the same procedure, but without need for reconstruction, is the additional work involved in placing either a free tissue graft, myocutaneous flap, or other reconstructive techniques, such as a free gastric patch in place, using microvascular techniques. While the reconstructive technique can obviously be billed as a secondary procedure, there is extra work and complication in suturing in such a device.

Additionally, all reconstructive techniques fail to provide sensation to the pharynx following reconstruction. Such lack of sensation leads to aspiration and difficulty in feeding. This complicates the post operative course of such patients demanding coordination with swallowing experts, and time and counseling the family and patient. This additional work necessary for Code 31395 is captured in the AAO-HNS survey data for this procedure.

Public Comments

30-Jun-95

Code: 31395

1995 RVUs: 26.19

Recommended RVUs: 55.00

Ratio:

Long Descriptor: Pharyngolaryngectomy, with radical neck dissection; with reconstruction

Reference Set (y/n): N Global Period: 090 Frequency: 119 Impact: 3428

Source: 2 Year: 92 Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
31395	50	50	0	0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31395	130	122	-3.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31395	93.1	95.1	1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31395	general surgery	4.9
	general/family practice	3.3
	group practices	6.6
	otolaryngology	80.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
31395	141	12.5	MALIGNANT NEOPLASM OF TONGUE
	148	12.5	MALIGNANT NEOPLASM OF HYPOPHAR
	149	12.5	MALIGNANT NEOPLASM OF OTHER AND

Public Comments

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31395							
AAOHNS		090	090	29.62	26.19	0.88	26.19

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31395								
AAOHNS	26.19	26.19	0.88	1.00	1.00	1.00	55.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
31395								
AAOHNS	090	29.62		38		374		50

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31395									
AAOHNS		1.0		10	14.0		10	2.5	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
31395									
AAOHNS		15		55.00	26.19	ot	3		0.051

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	5.55	090
42440	Excision of submandibular (submaxillary) gland	6.61	090
21330	Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation	5.03	090
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	9.56	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The respondents to our survey concerning CPT Code 31541 all felt that the relative work of this procedure fell into the range of the reference services even though CPT Code 31541 has a 0 day global period in contrast to the 90 day global period of the reference services.

The median pre service time of CPT Code of 31541 of 45 minutes exceeds the pre service time for any of the reference services. Similarly, the intra service median time for CPT Code 31541 of 60 minutes is consistent with the range of values for the reference services.

The immediate post service time for CPT Code 31541 of 20 minutes of the day of procedure is less than that of the reference services.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The work inherent in performing a stripping of the vocal cords utilizing the operating microscope and/or excision of small benign or malignant tumors is an exacting science which is increasing in its utilization. There has been a greater emphasis on voice saving procedures for early cancers of the larynx. As such, the margin for error in excision of these lesions (1-2mm) is greater than that for traditional open techniques. On the other hand, inadequate excision of tumors not matter what the technique or approach will result in recurrence of this lesion, and so there is a greater burden of responsibility on the operating surgeon to insure that he has done an adequate procedure. There is no assistant or other individual who can help the surgeon at this time, so that the mental stress and effort is considerable.

Additionally, there is a greater emphasis on and acceptable vocal result following this type of surgery. The surgeon is confronted with the need to balance the amount of tissue removed with leaving a satisfactory amount of vocal cord for phonation.

The Harvard data concerning this procedure failed to capture the increased amount of work required in this procedure. In addition, the advent of improved microsurgical techniques has allowed this procedure to be extended to patients who otherwise would have been subjected to open surgical operations.

Public Comments

30-Jun-95

Code: 31541

1995 RVUs: 3.56

Recommended RVUs: 5.50

Ratio:

Long Descriptor: Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope

Reference Set (y/n): N Global Period: 000 Frequency: 10,438 Impact: 20250

Source: 1 Year: 92 Public Comment Letter: 338

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
31541	32.5	4.5	8	43.7	16.4	0	0.4	11.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31541	11312	11090	-1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31541	17.9	15.7	-1.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31541	group practices	2.1
	otolaryngology	95.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
31541	161	3.8	MALIGNANT NEOPLASM OF LARYNX
	212	1.9	BENIGN NEOPLASM OF RESPIRATORY A
	235	1.1	NEOPLASM OF UNCERTAIN BEHAVIOR O
	239	1	NEOPLASMS OF UNSPECIFIED NATURE

Public Comments

30-Jun-95

476	1.1	CHRONIC LARYNGITIS AND LARYNGOT
478	12.6	OTHER DISEASES OF UPPER RESPIRATO
784	4	SYMPTOMS INVOLVING HEAD AND NEC

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31541							
AAOHNS		000	000	3.85	3.56	0.92	3.56

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amascod
31541								
AAOHNS	3.56	3.56	0.92	1.00	1.00	1.00	5.50	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
31541								
AAOHNS	000	3.85		23		42		23

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31541									
AAOHNS		0.5		10	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
31541									
AAOHNS		0		5.50	3.56	ot	3		0.061

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 31561 Global Period: 000 Current RVW: 4.90 Recommended RVW: 8.13

CPT Descriptor: Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope

Source and Summary of Comment to HCFA on this service:
AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Usually adult patient with bilateral vocal cord paralysis and consequent laryngeal airway obstruction. Patient usually tracheotomy dependent with desire to be made independent of tracheostomy.

Description of Pre-Service Work: Meet and talk with patient (and family); obtain operative consent; review lab studies; prepare for operating room; set up laser (may need to calibrate).

Description of Intra-Service Work: Allow induction of general anesthesia, place endoscope; place microscope, perform surgical procedure through scope; in many cases with use of laser. Monitor patients as he awakens.

Description of Post-Service Work: Accompany patient to recovery room area, write orders. Talk with family; do post operative report, may use feeding tube temporarily, trach care; see patient later that day or more times. See patient in the morning and arrange discharge; discharge note. Later removal of tracheostomy tube, monitor for airway problem; see in follow up.

SURVEY DATA:

Specialty: Otolaryngology—Head and Neck Surgery

Sample Size: 47 Response Rate (%): 64.00 Median RVW: 8.13

25th Percentile RVW: 6.75 75th Percentile RVW: 11.13 Low: 4.80 High: 15.00

Median Pre-Service Time: 60 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 98 Low: 40 High: 150

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>15</u>	<u>1</u>
Office:	<u>0</u>	<u>0</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	5.55	090
42440	Excision of submandibular (submaxillary) gland	6.61	090
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material	11.64	090
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	6.04	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 31561 was felt to be of the same general magnitude as the range of the reference procedures even though the reference procedures were 90 day global surgical operations and laryngoscopy with arytenoidectomy is a 0 day global procedure.

The median pre service of 60 minutes from our survey for CPT Code 31561 is greater than the pre operative duration for any of the reference procedures. Similarly, the intra service time of 90 minutes from our survey for CPT Code 31561 is consistent with the range of intra operative times for each of the reference services.

The intensity of CPT Code 31561 is similar to that of a stapedectomy or a submandibular gland excision. In fact, the very real risk of potential airway compromise for patients undergoing arytenoidectomy is significant.

The post operative time of course is truncated due to the fact that this is a 0 day global procedure. It does, however, involve a mean of 30 minutes of post service time on the day of procedure in one visit in the hospital prior to release of 15 minutes.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The number and scope of patients presenting for laser arytenoidectomy has increased in the past five years. The majority of our respondents indicated that the patients they were seeing were more complex and that the setting for conducting this operation had moved from an inpatient to an outpatient area. They also felt that the vignette captured the typical patient undergoing this operation.

Arytenoidectomy, whether by traditional surgical means or use of the laser is an exacting procedure where an incremental improvement in the patient's airway is desired to provide an adequate port for ventilation while preserving the patient's ability to phonate with a whisper. This is a compromise, trade-off operation, which demands a great deal of skill from the surgeon to achieve this balance. This exacting technique, is analogous to that of a stapedectomy (CPT Code 69660). The Harvard data has failed to capture the scope of work for this procedure.

Public Comments

30-Jun-95

Code: 31561 **1995 RVUs:** 4.9 **Recommended RVUs:** 7.00 **Ratio:**

Long Descriptor: Laryngoscopy, direct, operative, with arytenoidectomy, with operating microscope

Reference Set (y/n): N **Global Period:** 000 **Frequency:** 182 **Impact:** 382

Source: 1 **Year:** 92 **Public Comment Letter:** 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
31561	25	0	0	50	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31561	183	224	10.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31561	43.7	38.4	-2.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31561	group practices	3.6
	otolaryngology	95.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
31561	478	18.8	OTHER DISEASES OF UPPER RESPIRATO
	748	6.3	CONGENITAL ANOMALIES OF RESPIRAT

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31561							
AAOHNS		000	000	5.22	4.90	0.94	4.90

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31561								
AAOHNS	4.90	4.90	0.94	1.00	1.00	1.00	7.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
31561								
AAOHNS	000	5.22		21		66		35
AAOHNS	000	5.22		21		66		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31561									
AAOHNS		0.5	*	10	0.0		0	0.0	0.0
AAOHNS		0.5	*	10	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
31561									
AAOHNS		0		7.00	4.90	ot	3		0.062
AAOHNS		0		7.00	4.90	ot	3		0.062

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 31571 Global Period: 000 Current RVW: 3.52 Recommended RVW: 5.90

CPT Descriptor: Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope

Source and Summary of Comment to HCFA on this service: AAO-HNS.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Usually an adult patient with vocal cord paralysis and chronic or life threatening aspiration or with breathy or weakened voice. May be patient with other forms of vocal dysfunction such as spastic dysphemia. Procedure done under general anesthesia usually.

Description of Pre-Service Work: Meet and talk with patient and obtain operative consent; review lab studies; be certain infector and material is ready; prepare for OR.

Description of Intra-Service Work: Wait for intravenous sedation, administer topical/local anesthesia to larynx and pharynx; place scope, set up and work through microscope, perform injection with meticulous technique; assess immediate result, may injections and assessments, disassemble equipment.

Description of Post-Service Work: See patients in recovery room, write orders, do operative note, see patient later in same day, discharge next morning, discharge not, post op discussion with patient, discharge summary.

May do post op stroboscopic exam and video recording.

SURVEY DATA:

Specialty: Otolaryngology—Head and Neck Surgery

Sample Size: 47 Response Rate (%): 64.00 Median RVW: 5.90

25th Percentile RVW: 5.00 75th Percentile RVW: 6.53 Low: 2.50 High: 9.56

Median Pre-Service Time: 45 Median Intra-Service Time: 40

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 20 High: 90

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>25</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>10</u>	<u>1</u>
Office:	<u>0</u>	<u>0</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	5.55	090
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	5.55	090
42440	Excision of submandibular (submaxillary) gland	6.61	090
21330	Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation	5.03	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

It is important to note that the surveyed code, CPT Code 31571 is a 0 day global compared to the 90 day global periods for each of the reference services. On the other hand, the respondents to our survey felt that these reference services captured the relative amount of work involved in CPT Code 31571.

The pre service time for CPT Code 31571 is greater than that expressed in the Harvard data for any of the reference services.

The mean intra service time of 40 minutes for CPT Code 31571 is similarly consistent with the intra service times for each of the reference services.

There is a difference in post procedure time of CPT Code 31571 reflecting the fact that it is a 0 day global with approximately 25 minutes spent following the procedure and 1 10 minute visit in the hospital.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Laryngoscopy with injection into the vocal cords of therapeutic materials (CPT Code 31571) is generally performed for individuals with vocal cord paralysis due to a number of causes. The most common material injected is either Teflon or gelfoam.

The increased pre operative work in this procedure compared with those of the references is due to the time it takes to perform the pre operative set up and to adequately anesthetize the patient. This procedure is done under topic/local anesthesia so that the patient can attempt to phonate during the operation and assist the surgeon in determining the endpoint for this procedure.

The intra service duration of work 40 minutes is consistent with the reference services. This additionally is greater than that observed in the Harvard data for this procedure.

Public Comments

30-Jun-95

Code: 31571

1995 RVUs: 3.52

Recommended RVUs: 5.00

Ratio:

Long Descriptor: Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope

Reference Set (y/n): N Global Period: 000 Frequency: 473 Impact: 700

Source: 1 Year: 92 Public Comment Letter: 338

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
31571	33.3	0	0	22.2	0	0	11.1	11.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31571	527	462	-6.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31571	28.3	22.9	-2.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31571	otolaryngology	98.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
31571	231	2.8	CARCINOMA IN SITU OF RESPIRATORY S
	464	2.8	ACUTE LARYNGITIS AND TRACHEITIS
	478	22.2	OTHER DISEASES OF UPPER RESPIRATO
	507	2.8	PNEUMONITIS DUE TO SOLIDS AND LIQ
	784	8.3	SYMPTOMS INVOLVING HEAD AND NEC

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31571							
AAOHNS		000	000	3.83	3.52	0.92	3.52

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31571								
AAOHNS	3.52	3.52	0.92	1.00	1.00	1.00	5.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
31571								
AAOHNS	000	3.83		19	*	43		30

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31571									
AAOHNS	*	0.5	*	10	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
31571									
AAOHNS	*	0		5.00	3.52	ot	3		0.063

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 31587 Global Period: 090 Current RVW: 7.98 Recommended RVW: 10.00

CPT Descriptor: Laryngoplasty, cricoid split

Source and Summary of Comment to HCFA on this service: AAO-HNS.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a neonate who has been intubated and is being weaned from the ventilator. The patient may have mild congenital subglottic stenosis or acquired subglottic stenosis and also may have other problems such as bronchopulmonary dysplasia. The child will have failed multiple attempts at extubation and is frequently below normal weight.

Description of Pre-Service Work: This includes reviewing the patient's lab. values, the preoperative ventilator settings, and the most recent radiographs as well as talking to the family about the procedure, planning the operative care with the intensive care staff since the patient will need to be paralyzed or heavily sedated, planning intra operative care with anesthesia, preparation of equipment in the operating room, waiting for the patient to arrive in the operating room, positioning the patient, scrubbing, and draping the patient.

Description of Intra-Service Work: An incision is made in the neck, dissection is carried out between the strap muscles, the trachea and larynx are identified, and an incision is made from approximately the first or second tracheal ring upwards through the cricoid cartilage and into the lower part of the laryngeal cartilage but not into the anterior commissure of the vocal cords (very important not to violate the anterior commissure). In some patients the posterior part of the larynx must be split (15-20%) which has the risk of tracheal esophageal fistula. This latter patient would have a very severe stenosis. A larger endotracheal tube is inserted, sutures are used to hold the edges of the split cartilages laterally and the wound closed in layers (much like a total laryngectomy).

Description of Post-Service Work:

- a. Day of surgery: Dictation taking patient to ICU, orders, talking to family, getting ventilator set. Visit later same day surgery and talk again to family.
 - b. Days 1-7: Post operatively : ICU visits 2/day.
 - c. Days 8,9: Floor care each day.
 - d. Day 10: Discharge day.
 - e. Office visits.
 - f. Follow-up.
-

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery

Sample Size: 48 Response Rate (%): 65.00 Median RVW: 10.00

25th Percentile RVW: 9.50 75th Percentile RVW: 14.00 Low: 6.00 High: 21.00

Median Pre-Service Time: 60 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 143 Low: 30 High: 240

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>90</u>	<u>6</u>
Other Hospital:	<u>52.5</u>	<u>4</u>
Office:	<u>45</u>	<u>3</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
42440	Excision of submandibular (submaxillary) gland	6.61	090
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	5.55	090
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	9.86	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The respondents to the survey for 31587 all felt that the relative work value of this code was greater than that for the reference procedures. On the other hand, the initial approach and skeletonization of the larynx necessary to perform a cricoid split is similar in concept to that of a thyroidectomy (60220) and also requires the technical skill of a nasal septoplasty (30520). Specifically, the median pre service time of 60 minutes exceeded the Harvard values for any other reference services. Similarly, the intra service time was well within the range of values for the reference services. In fact only CPT Code 60220 at 159 minutes intra service time exceeded that of the value for our survey for CPT Code 31587.

The post operative phase of care for patients undergoing cricoid split is significantly more than any of the reference procedures. Our respondents indicated a median of 30 minutes on the day of the operation. Six visits were made to the intensive care unit for a total of 90 minutes, as well as four visits during the patients remaining hospitalization for a total of 52.5 minutes.

A patient would be examined in the office on three occasions of 15 minutes each.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Increasingly, infants who ordinarily would have been a candidate for a tracheotomy in years gone by have been subjected to cricoid split as an alternative. This procedure carries with it much of the same risk of pediatric tracheotomy, but additionally, has the risks of maintaining endotracheal intubation in the face of an open tracheal wound. As such, there is a significant risk of pneumothorax as well as air way loss should the endotracheal tube become dislodged.

There is also an increased amount of pre operative counseling necessary for the parents of such a child to explain to them the fact that should this procedure fail, a tracheotomy would be necessary. This is a confusion situation to explain concretely to parents who are necessarily anxious concerning the well being of their child.

Public Comments

30-Jun-95

Code: 31587

1995 RVUs: 7.98

Recommended RVUs: 12.00

Ratio:

Long Descriptor: Laryngoplasty, cricoid split

Reference Set (y/n): N

Global Period: 090

Frequency: 39

Impact: 157

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
31587	0	0	100	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31587	34	26	-12.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31587	50	38.5	-5.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31587	group practices	7.7
	otolaryngology	92.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
31587	478	25	OTHER DISEASES OF UPPER RESPIRATO

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31587								

Public Comments

30-Jun-95

AAOHNS	090	090	8.75	7.98	0.91	7.98
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
31587								
AAOHNS	7.98	7.98	0.91	1.00	1.00	1.00	12.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
31587								
AAOHNS	090	8.75		24	*	65		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31587									
AAOHNS	*	1.0	*	10	4.0	*	9	1.3	3.2

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
31587									
AAOHNS	*	12		12.00	7.98	ot	3		0.064

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 31750 Global Period: 090 Current RVW: 9.05 Recommended RVW: 15.00

CPT Descriptor: Tracheoplasty; cervical

Source and Summary of Comment to HCFA on this service: AAO-HNS.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old male with a history of head injury that required long term intubation and subsequent tracheostomy which resulted in tracheal stenosis. The patient presents with shortness of breath and audible inspiratory and expiratory stridor. Blood gas studies show chronic hypoxia and hypercapnea. There is a thick scar in the anterior cervical area at the site of the previous tracheostomy.

Description of Pre-Service Work: The patient & family are counselled. The patient is positioned, prepped, and draped.

Description of Intra-Service Work: The procedure must begin with securing the airway. Severe stenosis may make intubation difficult or impossible, and an emergency tracheostomy may be required which is made more difficult by the presence of the scar from the previous tracheostomy. A cervical incision is made down to the trachea, avoiding damage to the overlying thyroid gland, the adjacent major neck vessels and the recurrent laryngeal nerves.

The tracheal lumen is opened and the area of stenosis examined. Scar is excised, taking care not to enter the esophagus posteriorly. De-nuded cartilage is covered by mucosa utilizing adjacent transfer flaps or free buccal mucosal grafts which are sutured in place with the aid of the operating microscope. After the incision is closed, a post operative chest radiograph must be take to make sure that there is no pneumothorax.

Description of Post-Service Work: The stay in the ICU is usually 2 or 3 days to make sure that the airway is secure before transferring to the floor. Two visits a day for at least 15 minutes each are required to make sure that the patient is progressing properly. Vigorous pulmonary toilet is required to prevent atelectasis.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery

Sample Size: 47 Response Rate (%): 0.66 Median RVW: 15.00

25th Percentile RVW: 12.00 75th Percentile RVW: 18.00 Low: 6.00 High: 23.00

Median Pre-Service Time: 60 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 210 Low: 30 High: 510

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>55</u>	<u>2</u>
Other Hospital:	<u>60</u>	<u>3</u>
Office:	<u>60</u>	<u>4</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
31360	Laryngectomy; total, without radical neck dissection	15.19	090
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The respondents to the AAO-HNS survey concerning CPT Code 31750 agreed that its work value fell into the range of the references. In particular, the median pre service, intra service and post service times were very comparable to those of the Harvard values of the reference services. In point of fact, more post operative work was required of CPT Code 31750 than any of the key reference services. This is indicative of the necessary airway management for such patients undergoing cervical tracheoplasty. This included 30 minutes of work on the day of the procedure, 2 ICU visits totaling 55 minutes, 3 hospital visits of 20 minutes each and 4 office visits of 15 minutes each.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Cervical tracheoplasty (CPT Code 31750) is plastic surgery of the larynx. A great deal of skill and knowledge is necessary to accomplish these procedures with any degree of success. The Tracheal Lumen in all of these cases is narrowed, as that is the reason this is being done. Because of the physics and geometry of the airway, there is a logarithmic narrowing of the Tracheal Lumen with an arithmetic decrease in the diameter of the airway. Due to scarring and occasionally previous procedures, excess tissue available for restoration of the airway is quite limited. A major threat of hemorrhage, airway loss, atelectasis or pneumothorax is always present.

Public Comments

30-Jun-95

Code: 31750

1995 RVUs: 9.05

Recommended RVUs: 15.00

Ratio:

Long Descriptor: Tracheoplasty, cervical

Reference Set (y/n): N

Global Period: 090

Frequency: 132

Impact: 785

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS, APSA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
31750	0	0	0	50	25	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
31750	148	142	-2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
31750	62.2	71.8	4.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
31750	general surgery	4.2
	general/family practice	2.8
	group practices	5.6
	otolaryngology	83.1
	thoracic surgery	4.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
31750	161	6.3	MALIGNANT NEOPLASM OF LARYNX
	519	12.5	OTHER DISEASES OF RESPIRATORY SYS

Public Comments

30-Jun-95

V44	6.3	ARTIFICIAL OPENING STATUS
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
31750							
AAOHNS		090	090	9.24	9.05	0.98	9.05

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amascod
31750								
AAOHNS	9.05	9.05	0.98	1.00	1.00	1.00	15.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
31750								
AAOHNS	090	9.24		27	*	111		

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
31750									
AAOHNS		1.0	*	10	4.5	*	10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
31750									
AAOHNS	*	10		15.00	9.05	ot	3		0.040

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 41135 Global Period: 090 Current RVW: 14.29 Recommended RVW: 21.15

CPT Descriptor: Glossectomy; partial, with unilateral radical neck dissection

Source and Summary of Comment to HCFA on this service: AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 55-60 year old white male with sore mouth for 2-3 months, ear pain, weight loss, oral bleeding. One month history of a neck mass. Associated medical problems of cardiac chest pain, hypertension.

Description of Pre-Service Work:

Review of records
Informed consent
Equipment preparation
Dressing, scrubbing, and waiting
Scrubbing and preparing patient

Again excludes staging endoscopy (31535, 43200)

Description of Intra-Service Work: Partial glossectomy with neck dissection involves performing a standard or modified neck dissection, along with partial resection of the tongue for control of the primary tumor. This is analogous in work to 31365, laryngectomy and neck dissection, except that the tumor resection in 41135 is accomplished under the cover of the mandible which makes this procedure more difficult.

The neck is incised for cervical surgery. A neck dissection is completed. The incisions are extended to provide access to the oral cavity. This operation may be done as a "pull-through" or as a lip splitting procedure. The margins of the tumor in the tongue are identified and the tumor is excised with a margin of 1 to 2 cms. The margins are checked by frozen section analysis. At a point in the operation, a tracheotomy is usually performed to secure the airway postoperatively and to provide exposure to the field.

Estimate includes closure either primarily or with split thickness skin graft. In addition, tracheotomy (31600) is often performed in conjunction with the case.

Description of Post-Service Work: 5 days in hospital care with or without first night ICU. Visits, etc. same as others described.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery

Sample Size: 46 Response Rate (%): 67.00 Median RVW: 21.15

25th Percentile RVW: 18.38 75th Percentile RVW: 25.00 Low: 14.00 High: 40.00

Median Pre-Service Time: 90 Median Intra-Service Time: 240

50th Percentile Intra-Svc Time: 225 75th Percentile Intra-Svc Time: 300 Low: 135 High: 400

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>35</u>	
ICU:	<u>42.5</u>	<u>3</u>
Other Hospital:	<u>100</u>	<u>7</u>
Office:	<u>60</u>	<u>4</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
31360	Laryngectomy; total, without radical neck dissection	15.19	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 41135 describing a partial glossectomy with a unilateral radical neck dissection is valued significantly greater than either of the reference procedures. This operation combines performance of a neck dissection, in conjunction with removal of a portion of the tongue. This operation is done under the cover of the mandible, which makes this procedure more difficult in many respects than when the mandible is removed as part of the specimen.

The reference services described major head and neck procedures similar to that of the reference service, but are not directly related. The median pre service time, intra service time and post service time for the CPT 41135 are greater than the Harvard data and relative work units for the two reference codes.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT Code 41135 describes a procedure whereby cancer of the mobile tongue is treated with a unilateral neck dissection and resection of the tongue, but without removal of the intervening mandible. This procedure, which at first glance be thought of as less extensive than an operation which removes the jaw bone, is in point of fact difficult in itself, due to the work of performing the operation under the cover of the mandible. Previously, additional exposure could be afforded by dividing the patients lower lip. Today, however, due to patient preferences, this is not done as frequently, additionally limiting the exposure for this type of surgery. The increased work needed to perform this operation in these circumstances is reflected in the AAO-HNS survey data for CPT Code 41135.

Public Comments

30-Jun-95

Code: 41135

1995 RVUs: 14.29

Recommended RVUs: 27.00

Ratio:

Long Descriptor: Glossectomy, partial, with unilateral radical neck dissection

Reference Set (y/n): N Global Period: 090 Frequency: 277 Impact: 3521

Source: 2 Year: 92 Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFPRS, AAO-HNS

Societies Wishing to Comment: ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
41135	25	0	0	25	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
41135	273	292	3.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
41135	90.5	90.4	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
41135	general surgery	12.3
	group practices	4.8
	otolaryngology	77.4
	plastic surgery	2.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
41135	141	25	MALIGNANT NEOPLASM OF TONGUE

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
41135							
AAOHNS		090	090	20.35	14.29	0.70	14.29

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
41135								
AAOHNS	14.29	14.29	0.70	1.00	1.00	1.00	27.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
41135								
AAOHNS	090	20.35		37	*	223		65

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
41135									
AAOHNS	*	1.5	*	10	13.5	*	10	1.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
41135									
AAOHNS	*	10		27.00	14.29	ot	3		0.047

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 41150 Global Period: 090 Current RVW: 19.36 Recommended RVW: 21.00

CPT Descriptor: Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection

Source and Summary of Comment to HCFA on this service: AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An elderly 80 year old female in a nursing home is brought in with complaint of mouth pain, blood in the saliva, pain on swallowing, and unexplained weight loss. History of diabetes, congestive heart failure, arthritis. She is diagnosed as having squamous cell carcinoma of mouth extending into the gingiva. There is no evidence of neck metastasis on clinical exam on MRI.

Description of Pre-Service Work:

Review of records
Solicitation of informed consent
Preparation of equipment
Dressing, scrubbing, waiting
Scrubbing and preparing patient
Type of visits (excluding staging endoscopy):

It should be noted for all the head and neck cancers that a separate outpatient staging endoscopy with biopsies is performed. All patients have pre-operative chest x-ray, CT or MRI scan, blood tests, EKG and significant preoperative counselling of alternatives and, if the surgery is chosen, advised consent.

Description of Intra-Service Work: The patient is placed on the operating room table in a supine position and prepared for major head and neck surgery. In most instances, a preparatory tracheotomy will be performed (separate code).

The surgery may be approached via a facial degloving incision or a lip-splitting incision. The affected area of the mandible involved with cancer is outlined and mandibular osteotomies are performed. The tongue is grasped and the tumor resected from the tissues of the tongue, floor of mouth, mandible, soft palate and pharynx. Frozen section analysis of the margins is performed.

The wound is closed primarily, a skin graft may be performed, a pedicled myocutaneous flap employed or a free tissue transfer utilized for reconstruction. If primary closure is possible, attention is given to insuring that there is no tethering of the tongue or other oral tissues.

Suction drains are inserted and the wound is closed in layers. The patient is taken to the ICU.

The time estimate is based on the fact that the closure is performed without flap reconstruction, that is, by primary closure. Were a flap to be employed, the time would increase significantly. Does not include any reconstruction or tracheostomy.

Description of Post-Service Work: 7 days total as noted. ICU or highly trained hospital ward 1 day, and 6 total additional days. Visits 2 times per day.

SURVEY DATA:Specialty: American Academy of Otolaryngology—Head and Neck SurgerySample Size: 46 Response Rate (%): 65.00 Median RVW: 21.0025th Percentile RVW: 16.75 75th Percentile RVW: 23.25 Low: 14.00 High: 40.00Median Pre-Service Time: 90 Median Intra-Service Time: 21025th Percentile Intra-Svc Time: 180 75th Percentile Intra-Svc Time: 255 Low: 60 High: 360

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>35</u>	
ICU:	<u>60</u>	<u>3</u>
Other Hospital:	<u>105</u>	<u>7</u>
Office:	<u>75</u>	<u>5</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
31360	Laryngectomy; total, without radical neck dissection	15.19	090
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
42440	Excision of submandibular (submaxillary) gland	6.61	090
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	9.86	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 41150, similar to the reference procedures, is a major head and neck operation. This code describes removal of a portion of the patient's tongue, along with resection of the floor of the mouth on the same side, and a portion of the jaw bone or mandible. This procedure is customarily done for patients who present with epidermoid carcinoma of the larynx. The median pre service time, intra service time, and post service time are all greater than any of the key reference services from the Harvard data. This is also reflected in the higher RVW recommended for this service in comparison to the reference codes.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT Code 41150 represents a major surgical operation performed for patients with cancer of the head and neck. This operation involves removal of the mandible, floor of the mouth and a portion of the tongue, encompassing the tumor in a three dimensional sense. This operation is done for those occasional patients who do not require a formal neck dissection.

The lack of a preparatory neck dissection actually limits some of the surgeon's ability to pre resection delineate the important structures of the head and neck which must be preserved in this operation. As a result, much of this surgical time is spent identifying, preserving and protecting such structures so that they will not be injured during the subsequent resection of the cancer. There is a real risk of stroke, significant hemorrhage, and death from this procedure.

The extra technical skill, mental effort and judgment needed to perform this procedure, particularly realizing the exposure limitations is reflected in the survey data collected by the AAO-HNS.

CMD Comments

30-Jun-95

Code: 41150

1995 RVUs: 19.36

Recommended RVUs: 22.94

Ratio: 0.18

Long Descriptor: Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 290 **Impact:** 1038.2

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
41150			
41140	REMOVAL OF TONGUE	23.46	090
41145	TONGUE REMOVAL; NECK SURGERY	27.58	090

CMD Comment:

Close to 41140 in total work.

Societies Wishing to Survey: AAFPRS, AAO-HNS

Societies Wishing to Comment: ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
41150	78.9	21.1	0	31.6	0	0	0	11.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
41150	344	328	-2.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
41150	88.2	87	-0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
41150	general surgery	9.1
	group practices	4.9
	other nonphysician prov	4
	otolaryngology	75.9
	plastic surgery	2.4

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

ICD9	Pct of Time Used	ICD9 Descriptor
41150		
141	5	MALIGNANT NEOPLASM OF TONGUE
143	2.5	MALIGNANT NEOPLASM OF GUM
144	5	MALIGNANT NEOPLASM OF FLOOR OF M
145	2.5	MALIGNANT NEOPLASM OF OTHER AND
146	2.5	MALIGNANT NEOPLASM OF OROPHARY
170	5	MALIGNANT NEOPLASM OF BONE AND

Harvard Data:

Comm	Modif	Packhrv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
41150							
AAOHNS		090	090	20.85	19.36	0.93	19.36
CMD		090	090	20.85	19.36	0.93	19.36

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
41150								
AAOHNS	19.36	19.36	0.93	1.00	1.00	1.00	33.50	338
CMD	19.36	19.36	0.93	1.00	1.00	1.00	22.94	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
41150								
AAOHNS	090	20.85		37	*	212		60
CMD	090	20.85		37	*	212		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
41150									
AAOHNS	*	1.5	*	10	13.5	*	10	1.0	4.5
CMD	*	1.5	*	10	13.5	*	10	1.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
41150									
AAOHNS	*	10		33.50	19.36	ot	3		0.052
CMD	*	10		22.94	19.36	ot	3		0.052

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 41155 Global Period: 090 Current RVW: 23.40 Recommended RVW: 25.60

CPT Descriptor: Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)

Source and Summary of Comment to HCFA on this service: CMD and AAO-HNS.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male with a 2-3 month history of oral bleeding, mouth pain, ear pain, 10 lb. weight loss, and a 6 week history of a neck mass. Patient has pre-existing hypertension, history of myocardial infarction 2 years ago, and adult-onset diabetes. The patient has squamous cell carcinoma of floor of mouth with unilateral neck metastasis.

Description of Pre-Service Work:

Review of records
Solicitation of informed consent
Preparation of equipment
Dressing, scrubbing, waiting
Scrubbing and preparing patient

It should be noted for all the head and neck cancers that a separate outpatient staging endoscopy with biopsies is performed. All patients have pre-operative chest x-ray, CT or MRI scan, blood tests, EKG and significant preoperative counselling of alternatives and, if the surgery is chosen, advised consent.

Description of Intra-Service Work: The patient is placed on the operating room table in a supine position and prepped and draped for head and neck surgery. Customarily, a preparatory tracheotomy is performed (separate code). A complete radical neck dissection is completed and left pedicled on the submandibular triangle.

The procedure may be accomplished with a visor flap or a lip-splitting incision. The affected area of the mandible involved with cancer is outlined and mandibular osteotomies are performed. The tongue is grasped and the tumor resected from the tissues of the tongue, floor of mouth, mandible, soft palate and pharynx. Frozen section analysis of the margins is performed.

The wound is closed primarily, a skin graft may be performed, a pedicled myocutaneous flap employed or a free tissue transfer utilized for reconstruction. If primary closure is possible, attention is given to insuring that there is no tethering of the tongue or other oral tissues.

Suction drains are inserted and the wound is closed in layers. The patient is taken to the ICU.

The time estimate is based on the fact that the closure is performed without flap reconstruction, that is, by primary closure. Were a flap to be employed, the time would increase significantly.

Description of Post-Service Work: Again ICU or highly trained hospital ward 1 day and 6 days total additionally (7 days altogether). Visits 2x/day with same follow-up.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery

Sample Size: 46 Response Rate (%): 65 Median RVW: 25.60

25th Percentile RVW: 22.66 75th Percentile RVW: 33.50 Low: 17.50 High: 55.00

Median Pre-Service Time: 90 Median Intra-Service Time: 320

25th Percentile Intra-Svc Time: 300 75th Percentile Intra-Svc Time: 390 Low: 180 High: 720

Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	<u>37</u>	
ICU:	<u>45</u>	<u>3</u>
Other Hospital:	<u>120</u>	<u>8</u>
Office:	<u>70</u>	<u>5</u>

KEY REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	RVW	Global Period
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
31360	Laryngectomy; total, without radical neck dissection	15.19	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 41155 is a classic “commando” procedure with a radical neck dissection, partial resection of the tongue, resection of the floor of the mouth, and mandible being accomplished in one procedure. As such, CPT Code 41155 essentially encompasses the work of CPT Code 41150 with 41135. This is the prototypical head and neck procedure. The median pre service, intra service and post service times from the AAO-HNS survey are all greater than that of the key reference services consistent with this procedure requiring more work.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT Code 41155 demands a high degree of technical skill, mental effort and judgment to competently perform. This procedure encompasses two of the major operations of head and neck surgery in a bundled code. Particularly in recent years, a number of patients presenting for this surgery following radiation therapy, has increased. This has placed additional demands on the surgeon, both at the time of the procedure due to technical problems with radiated tissue, as well as the threat of post operative fistula formation. The extra work involved in performing this procedure has not been realized in the Harvard data which forms the basis for the current Medicare work value. The AAO-HNS survey of surgeons performing head and neck surgery more accurately captures this information.

CMD Comments

30-Jun-95

Code: 41155 **1995 RVUs:** 23.4 **Recommended RVUs:** 29.72 **Ratio:** 0.27

Long Descriptor: Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 705 **Impact:** 4455.6

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
41155			
	41140 REMOVAL OF TONGUE	23.46	090
	41145 TONGUE REMOVAL; NECK SURGERY	27.58	090
	41150 TONGUE, MOUTH, JAW SURGERY	19.36	090

CMD Comment:

Increment over 41150 should be greater than 41145 over 41140

Societies Wishing to Survey: AAFPRS, AAO-HNS

Societies Wishing to Comment: ASPRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
41155	57.1	14.3	4.8	28.6	4.8	0	0	4.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
41155	905	765	-8.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
41155	92.3	93.2	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
41155		
	general surgery	12.8
	group practices	3.7
	otolaryngology	76.1
	plastic surgery	3.4

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

ICD9	Pct of Time Used	ICD9 Descriptor
41155		
141	6	MALIGNANT NEOPLASM OF TONGUE
143	1.2	MALIGNANT NEOPLASM OF GUM
144	2.4	MALIGNANT NEOPLASM OF FLOOR OF M
145	8.3	MALIGNANT NEOPLASM OF OTHER AND
146	2.4	MALIGNANT NEOPLASM OF OROPHARY
170	6	MALIGNANT NEOPLASM OF BONE AND
196	4.8	SECONDARY AND UNSPECIFIED MALIGN
V10	1.2	PERSONAL HISTORY OF MALIGNANT NE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
41155							
AAOHNS		090	090	25.43	23.40	0.92	23.40
CMD		090	090	25.43	23.40	0.92	23.40

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
41155								
AAOHNS	23.40	23.40	0.92	1.00	1.00	1.00	45.00	338
CMD	23.40	23.40	0.92	1.00	1.00	1.00	29.72	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
41155								
AAOHNS	090	25.43		36		326		74
CMD	090	25.43		36		326		74

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
41155									
AAOHNS		1.5		10	13.0		15	3.0	5.5
CMD		1.5		10	13.0		15	3.0	5.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
41155									
AAOHNS		15		45.00	23.40	ot	3		0.042

CMD Comments

30-Jun-95

CMD	15	29.72	23.40	ot	3	0.042
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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 42200 **Global Period:** 090 **1995 RVW:** 9.48 **Recommended RVW:** 12.70

CPT Descriptor: Palatoplasty for cleft palate, soft and/or hard palate only

Source and Summary of Comment to HCFA on this service: An Advisory Panel of surgeons representing the American Society of Plastic and Reconstructive Surgeons, the American Society of Maxillofacial Surgeons, the American Society for Reconstructive Microsurgery, the American Association for Hand Surgery, the American Association of Plastic Surgeons, and the American Society for Aesthetic Plastic Surgery reviewed the RVW relationship for the (Medicare) top ranked surgical codes for plastic and reconstructive surgery. The results of this review found code 42200 to be currently undervalued.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An otherwise healthy child is born with a cleft of the secondary "hard and/or soft palate." He presents at the age of 9-20 months for a palatoplasty. (e.g., Von Langenbeck, Wardill-Kilner, intervelo-veloplasty, Furlow)

Description of Pre-Service Work:

Pre-service work begins on the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural laboratory and imaging studies; and communicating with the patient's family to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include patient preparation; supervision of the positioning, prepping, and draping of the patient; and ensuring that the special surgical instruments and supplies that are necessary are present and available in the operative suite.

Description of Intra-Service Work:

After general oral endotracheal anesthesia has been induced and the anesthesiologist is satisfied that the monitoring equipment is functioning, the face is prepared and draped.

Exposure of the palate is gained through the insertion of a Dingman retractor. This critical step must ensure maintenance of the endotracheal tube position in the airway and the proper application of the blade to the base of the tongue.

Local anesthesia is placed in the palatal shelves. The operative plan is marked on the oral skin. The various flaps are developed with oral mucosa, muscle and nasal mucosal elements. Feeding and airway tubes are placed. Complete hemostasis is critical. Closure of each of these elements noted above is accomplished with interrupted sutures. Removal of the Dingman is just as critical as insertion to prevent accidental extubation.

Description of Post-Service Work:

Post-service work begins after extubation in the operating room and includes close monitoring of the patient's airway; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring and care of the incision; monitoring, care, and removal of all tubes; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging, pathology, and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

Survey n:	150	RVW	PRE	INTRA	POST						
Response:	27				Day 1	ICU		Hosp. - Other		Office	
Rate %:	18%		total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
low	7.34			53							
25th %	12.04			95							
med	12.70	60	120	30	0	0	30	2	60	4	
75th %	16.20		150								
high	20.00		180								

KEY REFERENCE SERVICE(S):

1995 RVWGlobal CPT Descriptor

12.04	090	40700	Repair cleft lip
12.73	090	42844	Extensive surgery of the throat

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Both of these key reference codes closely approximate the stress, technical skill and mental effort of palate repair.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

As indicated by the key reference services, cleft palate repair as published creates a RVW proportionality problem when compared with other codes in the family. The initial Harvard intensity value (IWPUT) for this service of 0.037 is proportionally too low compared to other cleft palate services. The recommended 12.70 RVW would be proportionally more appropriate.

In addition, the technique for this procedure has changed in the last few years due to an increasingly younger patient population.

Public Comments

30-Jun-95

Code: 42200

1995 RVUs: 9.48

Recommended RVUs: 11.75

Ratio:

Long Descriptor: Palatoplasty for cleft palate, soft and/or hard palate only

Reference Set (y/n): Y

Global Period: 090

Frequency: 28

Impact: 64

Source: 5

Year: 93

Public Comment Letter: 307

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAP, ASPRS

Societies Wishing to Comment: AAFPRS, AAO-HNS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
42200	100	0	0	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
42200	24	32	15.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
42200	41.7	31.3	-5.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
42200	general/family practice	6.3
	group practices	6.3
	interventional radiolog	6.3
	orthopedic surgery	6.3
	other nonphysician prov	6.3
	otolaryngology	62.5
	plastic surgery	6.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
42200			

Public Comments

30-Jun-95

749	25	CLEFT PALATE AND CLEFT LIP
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
42200							
ASPRS		090	090	8.63	9.48	1.10	8.61

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
42200								
ASPRS	9.48	9.48	1.00	1.10	1.00	1.00	11.75	307

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
42200								
ASPRS	090	8.63		26		123		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
42200									
ASPRS		1.0		10	4.5		10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
42200									
ASPRS		10		11.75	9.48	ot	3		0.037

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 42210 **Global Period:** 090 **1995 RVW:** 10.02 **Recommended RVW:** 16.96

CPT Descriptor: Palatoplasty for cleft palate with closure of the alveolar ridge (includes obtaining graft)

Source and Summary of Comment to HCFA on this service: AAOMS comment

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is a healthy child born with complete unilateral (or bilateral) cleft lip. The lip has been repaired successfully. The patient now presents at approximately age 18 months for elective palatoplasty and concomitant bone graft to the alveolar ridge with mucosal flaps (osseus alveoplasty). Note: This procedure includes the development of the mucosal flaps, the harvesting of the bone graft, the inset of the bone graft and the fixation of the bone graft.

Description of Pre-Service Work:

Pre-service work begins from the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural laboratory and imaging studies; and communicating with the patient's family to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include supervision of the anesthetic induction, prepping, and draping of the patient; and ensuring that the special surgical instruments and supplies that are necessary are present and available in the operative suite.

Description of Intra-Service Work:

After the satisfactory induction of anesthesia, the operative site is injected. The face and mouth are prepped and draped as well as the hip for the bone graft donor site.

Local infiltration of anesthetic containing adrenalin for hemostasis is done. Mucosal flaps are planned and elevated. Buccal mucosal flaps are outlined.

The bony gap is measured and a 3-dimensional drawing with precise measurements is completed. The plan is transferred to template material. The defect is packed with antibiotic soaked sponges while the bone graft is harvested.

Attention is turned to the iliac crest donor site where a skin incision is made and dissection is carried down to the flank muscles. These are split in the direction of their fibers and the iliac crest is exposed in the subperiosteal plane. A piece of the inner table is harvested leaving the crest edge intact if possible. A larger piece of bone than necessary is harvested with curettes. Some cancellous bone (marrow) is also harvested. The periosteum and muscle are repaired and the skin closed in layers. Drains are placed if required.

The bone graft is then sculpted to precisely fit the defect with power tools (burrs, etc.).

The sponges are removed and the bone surfaces freshened. The grafts are laid in place and final adjustments made. The cancellous bone graft is packed firmly into the remaining crevices. The mucosal flaps are laid in place and buccal mucosal flaps are incised and transposed into the defect. All suture lines are closed.

Description of Post-Service Work:

Post-service work begins with monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring and care of the incision; monitoring, care, and removal of drains, if used; and antibiotic, nutritional and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging, pathology, and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

Survey n:	150	RVW	PRE	INTRA	POST						
			total min	total min	Day 1	ICU		Hosp. - Other		Office	
					total min	total min	# visits	total min	# visits	total min	# visits
Response:	28										
Rate %:	19%										
low	12.04			90							
25th %	15.00			150							
med	16.96	60	180	30	0	0	40	2	60	4	
75th %	21.23		210								
high	25.00		300								

KEY REFERENCE SERVICE(S):

<u>1995 RVW</u>	<u>CPT</u>	<u>Descriptor</u>
16.92	21144	Reconstruct Mid-face - Lefort I
17.94	40845	Reconstruction of mouth
7.18	14040	Reconstruction of the face with flap

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The two reference codes, 21144 and 40845, are both quite similar in the anatomic region, the extent of dissection, and the visits involved. The technical skill and the psychological stress are level 4 (of 5).

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Proportionally, 42210 is not in appropriate alignment with 42200. It should be dealt with almost as a separate entity. However, the infrequency of this procedure provided a small response rate but relatively consistent numbers. A Service such as this is usually done only in relatively large cleft practices and should be considered a sophisticated procedure. It is apparent that the current RVW does not sufficiently include the work for the bone graft portion of the procedure.

Public Comments

30-Jun-95

Code: 42210

1995 RVUs: 10.02

Recommended RVUs: 12.33

Ratio:

Long Descriptor: Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)

Reference Set (y/n): N Global Period: 090 Frequency: 8 Impact: 18

Source: 1 Year: 92 Public Comment Letter: 186

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAP, ASPRS

Societies Wishing to Comment: AAFPRS, AAO-HNS

Trends Analysis - Beneficiary Information:

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
42210	8	10	11.8

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
42210	62.5	60	-1.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
42210	group practices	20
	other nonphysician prov	40
	otolaryngology	40

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
42210							

Public Comments

30-Jun-95

AAOMS	090	090	11.14	10.02	0.90	10.02
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
42210								
AAOMS	10.02	10.02	0.90	1.00	1.00	1.00	12.33	186

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
42210								
AAOMS	090	11.14		25	*	136		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
42210									
AAOMS	*	1.0	*	10	3.5	*	10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
42210									
AAOMS	*	10		12.33	10.02	ot	3		0.052

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 42260 Global Period: 090 1995 RVW: 4.17 Recommended RVW: 9.18

CPT Descriptor: Repair of nasal labial fistula

Source and Summary of Comment to HCFA on this service: AAOMS comment

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This is an otherwise healthy 14-year old male who was born with a unilateral cleft lip and palate. He underwent a lip repair at 18 months and a palate repair at 18 months of age. No attempt was made to close the alveolus in either operation. He presents now with an established nasal labial fistula, 4 mm in diameter, easily visible between the left lateral incisor tooth and the left canine, which are in good alignment. The patient seeks closure of this fistula to prevent further nasal regurgitation of fluids.

Description of Pre-Service Work:

Pre-service work begins the day before the surgery until the time of the procedure. This includes obtaining and reviewing pre-procedural laboratory and imaging studies; and communicating with the patient and patient's family to explain operative risks and benefits and to obtain informed consent. Other pre-operative services include personal and patient preparation; supervision of the positioning, prepping, and draping of the patient; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Description of Intra-Service Work:

After satisfactory induction of general anesthesia, the lips are retracted and the fistula visualized. An operative plan is outlined and local anesthesia containing adrenalin is infiltrated for hemostasis.

A "turn-over" flap is developed and rotated into the defect and sewn in place. A buccal sulcus flap is elevated and transposed into position and also sewn in place.

Topical antibiotics complete the regimen.

Description of Post-Service Work:

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring and care of the incisions, if used; and antibiotic and pain medication management. Discharge management includes the surgeon's examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of sutures; evaluation of periodic imaging, pathology, and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American Society of Plastic & Reconstructive Surgeons, Inc.

Survey n:	150	PRE	INTRA	POST-						
Response:	27			Day 1	ICU		Hosp. - Other		Office	
Rate %:	18%	total min	total min		total min	# visits	total min	# visits	total min	# visits
	RVW									
	low	6.00	45							
	25th%	8.00	75							
	med	9.18	90	30	0	0	20	1	60	4
	75th%	12.00	120							
	high	18.00	180							

KEY REFERENCE SERVICE(S):

1995 RVW	Global	CPT	Descriptor
7.18		14040	Reconstruction of face with flap

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

It is essentially a double flap repair (CPT 14040) but in a difficult bipplanar location.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT 42260 presents another proportionality problem. It is not valued in proper proportion with 42200 and 42210. It should be dealt with almost as a separate entity. However, the infrequency of this procedure provided a small response rate but relatively consistent numbers. Service such as this is usually done only in relatively large cleft practices and should be considered a sophisticated procedure.

The extra work between 42260 and 14040 is the extra technical expertise required in a tiny difficult location. The double flap is laid in a bipolar fashion which requires more mental effort in planning and execution than 14040.

Examination of the Harvard data indicates that the initial intra-service and post-service work times were much too low. The actual work has not changed in the last 5 years.

Public Comments

30-Jun-95

Code: 42260 **1995 RVUs:** 4.17 **Recommended RVUs:** 5.87 **Ratio:**

Long Descriptor: Repair of nasolabial fistula

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 20 **Impact:** 34

Source: 1 **Year:** 92 **Public Comment Letter:** 186

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAP, ASPRS

Societies Wishing to Comment: AAFPRS, AAO-HNS

Trends Analysis – Beneficiary Information:

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
42260	14	28	41.4

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
42260	50	42.9	-3.6

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
42260	gastroenterology	14.3
	general/family practice	7.1
	group practices	7.1
	other nonphysician prov	21.4
	otolaryngology	14.3
	plastic surgery	28.6
	urology	7.1

Claims-Level Diagnosis Information:

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
42260							
AAOMS		090	090	4.35	4.17	0.96	4.17

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
42260								
AAOMS	4.17	4.17	0.96	1.00	1.00	1.00	5.87	186

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
42260								
AAOMS	090	4.35		20	*	54		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
42260									
AAOMS	*	0.5		10	0.5	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
42260									
AAOMS	*	10		5.87	4.17	ot	3		0.037

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 42720 Global Period: 010 Current RVW: 2.61 Recommended RVW: 6.00

CPT Descriptor: Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach

Source and Summary of Comment to HCFA on this service: AAO-HNS.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Patient with severe pharyngitis or other head and neck source of infection. Patient is usually toxic with fever, high white count, difficulty swallowing and breathing. There is evidence of sepsis. Generally done on an emergency basis.

Description of Pre-Service Work: Generally emergency patients seen in emergency room. Examination, tests done and procedure scheduled the same night. Multiple visits are necessary to patient and family. Aspiration and airway concerns require close monitoring. Adjunctive procedures must be explained to patient and family (e.g. possible need for tracheotomy). Arranging and reviewing contrast enhanced CT scan.

Description of Intra-Service Work: After intubation, set up similar to tonsillectomy with more care needed in positioning. Drainage is done with approach similar to tonsillectomy with exploration of wound, irrigation. There is always concern about aspiration of abscess material and cardiac arrest.

Description of Post-Service Work: May need frequent checks for swelling and signs of undrained collection or loculation. Airway monitoring is generally needed. Patients are sometimes kept intubated for 24-48 hours. Patient is in ICU x 2 days.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery

Sample Size: 47 Response Rate (%): 64.00 Median RVW: 6.00

25th Percentile RVW: 4.50 75th Percentile RVW: 7.50 Low: 2.52 High: 12.00

Median Pre-Service Time: 60 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 45 Low: 10 High: 90

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 30

ICU: 25 2

Other Hospital: 50 3

Office: 0 0

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
42440	Excision of submandibular (submaxillary) gland	6.61	090
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	5.55	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre service work of CPT Code 42720 (60 minutes) is greater than the Harvard data for either of the reference services (22 minutes each). Similarly, the post service work for the surveyed procedure CPT Code 42720 is greater than either of the reference services.

The intra service work component (30 minutes) surveyed for CPT Code 42720 is less than that of either of the references but of the same magnitude. The intra operative work for CPT Code 30520 is 58 minutes and for CPT Code 42440 is 71 minutes.

Intraoral drainage of a retro pharyngeal abscess carries with it a particular risk of airway loss and bradycardia and cardiac arrest. This is at variance with the procedures listed as key references.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The general magnitude of the work involved for CPT Code 42720 is similar to that of both the reference procedures. This is taking into account the fact that the reference procedures are 90 day global and this procedure is a 10 day global. The Harvard survey data for CPT Code 42720 failed to take into account the amount of pre operative work, along with the immediate post operative work involved in this procedure. The intra operative component failed to capture the increased stress and anxiety due to the potential for airway compromise, aspiration and cardiac arrest.

Public Comments

30-Jun-95

Code: 42720 **1995 RVUs:** 2.61 **Recommended RVUs:** 6.00 **Ratio:**

Long Descriptor: Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach

Reference Set (y/n): N **Global Period:** 010 **Frequency:** 136 **Impact:** 461

Source: 1 **Year:** 92 **Public Comment Letter:** 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS, ACEP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
42720	50	25	50	75	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
42720	128	154	9.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
42720	60.9	64.9	2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
42720	general/family practice	3.9
	group practices	3.9
	other nonphysician prov	7.8
	otolaryngology	83.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
42720	475	12.5	PERITONSILLAR ABSCESS
	478	18.8	OTHER DISEASES OF UPPER RESPIRATO
	527	6.3	DISEASES OF THE SALIVARY GLANDS

Public Comments

30-Jun-95

933	6.3	FOREIGN BODY IN PHARYNX AND LARY
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
42720							
AAOHNS		010	010	2.77	2.61	0.94	2.61

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
42720								
AAOHNS	2.61	2.61	0.94	1.00	1.00	1.00	6.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
42720								
AAOHNS	010	2.77		13	*	21		20

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
42720									
AAOHNS	*	0.0		0	0.5	*	10	0.0	1.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
42720									
AAOHNS	*	10		6.00	2.61	ot	3		0.074

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 42725 Global Period: 090 Current RVW: 7.60 Recommended RVW: 9.50

CPT Descriptor: Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach

Source and Summary of Comment to HCFA on this service:
AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Toxic, possibly septic individual with abscess related to pharyngitis or other head and neck infection. Metabolic instability and compromise of swallowing and breathing are common. Airway control is often needed via intubation or tracheotomy. Nearly always an emergent situation.

Description of Pre-Service Work: Toxic patients in need of careful evaluation and assessment of airway and at risk for aspiration. Complex group of possible complications including mediastinitis and pharyngeal entry. Requires extensive discussion with patient and family. Monitoring of airway and signs of disease progression require multiple exams. Testing including CT scan requires careful review with radiologist. Going to OR with patient, positioning, prepping, and draping.

Description of Intra-Service Work: After the airway is secured incision and drainage is performed, dissection of great vessels and exploration for loculation is typical. Care is needed to avoid pharyngotomy and still completely open abscess cavity. Irrigation and partial closure follows.

Description of Post-Service Work: Frequent checks especially in toxic/septic patients along with repeated airway evaluation are needed especially when tracheotomy is not performed. Critical evaluation for inadequate drainage is done. Repeated dressing changes and packing changes are the rule.

SURVEY DATA:

Specialty: Otolaryngology—Head and Neck Surgery

Sample Size: 47 Response Rate (%): 64.00 Median RVW: 9.50

25th Percentile RVW: 7.50 75th Percentile RVW: 11.00 Low: 5.30 High: 9.75

Median Pre-Service Time: 60 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 90 Low: 20 High: 180

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 30

ICU: 35 2

Other Hospital: 60 4

Office: 40 3

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
42440	Excision of submandibular (submaxillary) gland	6.61	090
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	9.86	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre service work of CPT Code 42725 is greater than that of either of the key reference services according to Harvard data. Similarly, the post service time is of the same magnitude but the number of visits and their duration are increased according to our survey data in comparison to the Harvard generated information.

Incision and drainage of a retro pharyngeal abscess is a formal surgical procedure with entrance into the neck, similar to that of CPT Code 42440 or 60220. There is additional complexity to CPT Code 42725

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The pre operative work for CPT Code 42725 is greater than that of either of the reference procedures. This is due to the need to consult with other care givers regarding an individual who is toxic and possibly septic. Individuals presenting for CPT Code 42440 or 60220 generally are in good health without an antecedent illness.

The intra operative work for CPT Code 42725 is similar, but of a lesser magnitude than that of either of the reference procedures. This is reflected in the difference between our survey data of 60 duration intra service time compared to 71 minutes for CPT Code 42440 and 159 minutes for CPT Code 60220 according to Harvard data.

The chief difference between these operations appears to be the post operative work component. Here we have detailed that there a total of nine post operative visits spread between the intensive care unit, hospital and office, which is greater than the number of visits of either of the reference services. This post operative work will include continued monitoring of the patient's general status with regard to antibiotic prophylaxis and treatment, as well as advancing drains and handling the wound complications which may ensue following this procedure.

Public Comments

30-Jun-95

Code: 42725

1995 RVUs: 7.6

Recommended RVUs: 14.00

Ratio:

Long Descriptor: Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach

Reference Set (y/n): N

Global Period: 090

Frequency: 95

Impact: 608

Source: 7

Year: 93

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS, ACEP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
42725	0	0	50	100	50	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
42725	82	104	12.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
42725	84.1	82.7	-0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
42725	general surgery	5.8
	other nonphysician prov	11.5
	otolaryngology	76.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
42725	478	25	OTHER DISEASES OF UPPER RESPIRATO
	513	12.5	ABSCESS OF LUNG AND MEDIASTINUM

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
42725							
AAOHNS		090	090	5.35	7.60	1.42	5.04

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
42725								
AAOHNS	7.60	7.60	0.94	1.51	1.00	1.00	14.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
42725								
AAOHNS	090	5.35		21	*	49		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
42725									
AAOHNS	*	0.5		10	2.0	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
42725									
AAOHNS	*	10		14.00	7.60	ot	3		0.049

CMD Comments

30-Jun-95

Code: 60225 **1995 RVUs:** 11.65 **Recommended RVUs:** 13.31 **Ratio:** 0.14

Long Descriptor: Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 1,357 **Impact:** 2252.62

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
60225			
	60240 REMOVAL OF THYROID	15.66	090

CMD Comment:

Close to the work of 60240. Recommended value is 15% less.

Societies Wishing to Survey:

Societies Wishing to Comment: AAFPRS, AAO-HNS, ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
60225	29.4	2	15.7	68.6	3.9	2	2	7.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
60225	1436	1448	0.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
60225	88.9	82.7	-3.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
60225		
	general surgery	68.6
	group practices	2.2
	otolaryngology	22.8
	thoracic surgery	2.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
60225			
	161	2	MALIGNANT NEOPLASM OF LARYNX

CMD Comments

30-Jun-95

193	5.9	MALIGNANT NEOPLASM OF THYROID G
226	3.9	BENIGN NEOPLASM OF THYROID GLAN
237	2	NEOPLASM OF UNCERTAIN BEHAVIOR O
240	2.9	SIMPLE AND UNSPECIFIED GOITER
241	5.9	NONTOXIC NODULAR GOITER
242	2.5	THYROTOXICOSIS WITH OR WITHOUT G
245	1.5	THYROIDITIS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
60225							
CMD		090	090	11.53	11.65	1.01	11.65

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
60225								
CMD	11.65	11.65	1.01	1.00	1.00	1.00	13.31	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
60225								
CMD	090	11.53		30	*	122		

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
60225									
CMD		1.0	*	10	4.5	*	10	0.0	4.1

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
60225									
CMD	*	10		13.31	11.65	gs	3		0.056

CMD Comments

30-Jun-95

Code: 60252 1995 RVUs: 15.4 Recommended RVUs: 17.23 Ratio: 0.12

Long Descriptor: Thyroidectomy, total or subtotal for malignancy, with limited neck dissection

Reference Set (y/n): N Global Period: 090 Frequency: 485 Impact: 887.55

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
60252			
	60240 REMOVAL OF THYROID	15.66	090

CMD Comment:

Should be more work than 60240. Recommended value gives 10% more for the neck dissection.

Societies Wishing to Survey:

Societies Wishing to Comment: AAFPRS, AAO-HNS, ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
60252	41.7	0	9.1	75	0	0	0	8.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
60252	548	522	-2.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
60252	93.3	87	-3.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
60252		
	general surgery	62.5
	group practices	3.8
	otolaryngology	27
	thoracic surgery	2.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
60252			
	161	2.1	MALIGNANT NEOPLASM OF LARYNX

CMD Comments

30-Jun-95

174	2.1	MALIGNANT NEOPLASM OF FEMALE BR
193	20.8	MALIGNANT NEOPLASM OF THYROID G
196	2.1	SECONDARY AND UNSPECIFIED MALIGN
198	4.2	SECONDARY MALIGNANT NEOPLASM O
241	2.1	NONTOXIC NODULAR GOITER
252	2.1	DISORDERS OF PARATHYROID GLAND
478	2.1	OTHER DISEASES OF UPPER RESPIRATO

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
60252							
CMD		090	090	15.29	15.40	1.01	15.40

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
60252								
CMD	15.40	15.40	1.01	1.00	1.00	1.00	17.23	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
60252								
CMD	090	15.29		37	*	209		43

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
60252									
CMD	*	1.0	*	10	5.0	*	10	0.0	4.7

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
60252									
CMD	*	10		17.23	15.40	gs	3		0.047

CMD Comments

30-Jun-95

Code: 60254 **1995 RVUs:** 16.68 **Recommended RVUs:** 22.50 **Ratio:** 0.35

Long Descriptor: Thyroidectomy, total or subtotal for malignancy; with radical neck dissection

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 140 **Impact:** 814.8

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
60254			
	60240 REMOVAL OF THYROID	15.66	090

CMD Comment:

Radical neck dissection is considerably more work.

Societies Wishing to Survey:

Societies Wishing to Comment: AAFPRS, AAO-HNS, ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
60254	0	0	0	66.7	0	0	33.3	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
60254	158	158	0

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
60254	93	78.5	-7.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
60254		
	general surgery	34.2
	group practices	2.5
	otolaryngology	58.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
60254			
	237	8.3	NEOPLASM OF UNCERTAIN BEHAVIOR O
	252	8.3	DISORDERS OF PARATHYROID GLAND

CMD Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
60254							
CMD		090	090	16.66	16.68	1.00	16.68

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
60254								
CMD	16.68	16.68	1.00	1.00	1.00	1.00	22.50	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
60254								
CMD	090	16.66		38	*	242		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
60254									
CMD	*	1.0	*	10	8.0	*	10	0.0	5.2

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
60254									
CMD	*	10		22.50	16.68	gs	3		0.041

Public Comments

30-Jun-95

Code: 69100 1995 RVUs: 0.76 Recommended RVUs: 0.81 Ratio:

Long Descriptor: Biopsy external ear

Reference Set (y/n): N Global Period: 000 Frequency: 12,845 Impact: 642

Source: 2 Year: 92 Public Comment Letter: 409

Reference Services:

CMD Comment:

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Societies Wishing to Survey:

Societies Wishing to Comment: AAD, AAFPRS, AAO-HNS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
69100	58.7	15	1.7	18	2.7	0.5	0.5	6.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
69100	8253	13078	25.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
69100	1.2	0.7	-0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
69100	dermatology	84.9
	otolaryngology	9.1
	plastic surgery	2.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
69100	173	9.7	OTHER MALIGNANT NEOPLASM OF SKIN
	216	2.1	BENIGN NEOPLASM OF SKIN
	238	8.2	NEOPLASM OF UNCERTAIN BEHAVIOR O
	239	3.6	NEOPLASMS OF UNSPECIFIED NATURE

Public Comments

30-Jun-95

380	1.5	DISORDERS OF EXTERNAL EAR
692	1.6	CONTACT DERMATITIS AND OTHER ECZ
702	11.8	OTHER DERMATOSES
709	1.4	OTHER DISORDERS OF SKIN AND SUBCU

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
69100							
IND		000	000	0.72	0.76	1.06	0.76

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
69100								
IND	0.76	0.76	1.06	1.00	1.00	1.00	0.81	409

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
69100								
IND	000	0.72		6	*	10		5

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
69100									
IND	*	0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
69100									
IND	*	0		0.81	0.76	ot	3		0.047

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 69155 Global Period: 090 Current RVW: 17.03 Recommended RVW: 23.00

CPT Descriptor: Radical excision external auditory canal lesion; with neck dissection

Source and Summary of Comment to HCFA on this service: AAO-HNS.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52 year old man with a nine-month history of progressive otalgia and constant otorrhea was noted to have a 1.8 cm ulceration along the floor of his left external auditory canal. The tympanic membrane was intact. A 1.5 cm, mobile, nontender jugulodigastric lymph node was palpated. Biopsy confirmed the presence of a well-differentiated squamous cell carcinoma. High-resolution CT demonstrated: (1) limited erosion of the tympanic bone but no extension to the mastoid or middle ear; and (2) several high cervical lymph nodes which were suspicious for metastatic disease.

Description of Pre-Service Work: A partial temporal bone resection with a cervical lymphadenectomy is performed when a temporal bone cancer is limited to the external auditory canal with clinical or radiographic evidence or the cervical region.

Review of chart, lab radiographs. Discussion with patient and family. Informed consent. Position patient, place monitors, prep and drape patient. Wait on line placement.

Description of Intra-Service Work: A partial temporal bone resection involves the removal of the entire tympanic bone and the tympanic membrane. This includes a complete mastoidectomy to expose the vertical segment of the facial nerve and to screen for an unanticipated extension of the tumor. The entire tympanic bone, the tympanic membrane, and the cartilaginous portion of the external auditory canal, including a 2 cm margin of normal tissue, are removed en-bloc by drill curettage and sharp dissection.

A noncontiguous cervical lymphadenectomy is then performed. In this pathological setting, the dissection is typically carried to the level of the jugular bulb with preliminary exposure and mobilization of the facial nerve from the stylomastoid foramen to at least the pes anserinus.

The resulting anterior soft tissue defect is surfaced with a skin graft. The remainder of the repair is similar to that of performing a canal-wall-down mastoidectomy with tympanoplasty with ossicular chain reconstruction. The cavity resulting from a partial temporal bone resection, however, is always lined with non-adherent dressing and stented with non-absorbent packing.

Description of Post-Service Work: The patient is typically seen on the night of surgery in ICU to confirm his or her stability, inspect the dressings, and to discuss the details of the surgery with both the patient and family. The patient is then seen one or two times on his or her first postoperative day (CPT 99231). The patient is seen for a final time on the morning of their second postoperative day (CPT 99238), at which time the ear dressing is removed and the surgical site cleaned of debris, the graft donor site is inspected and cleaned, if necessary, and suction drains are removed from the neck. The patient and his or her family are given detailed verbal and written instructions regarding at-home care of the wounds. Prescriptions for medications are explained and provided. The patient encounter is detailed in the medical chart and a discharge summary is dictated and later reviewed and signed. The patient is seen in the office one week postoperatively to have their stent removed, the wound cleaned of granulation tissue and sutures removed. They are then seen one or two times a month during the global period, depending on their rate of healing.

SURVEY DATA:Specialty: American Academy of Otolaryngology—Head and Neck SurgerySample Size: 47 Response Rate (%): 64.00 Median RVW: 23.0025th Percentile RVW: 21.00 75th Percentile RVW: 28.00 Low: 16.00 High: 38.09Median Pre-Service Time: 90 Median Intra-Service Time: 28525th Percentile Intra-Svc Time: 240 75th Percentile Intra-Svc Time: 323 Low: 140 High: 600

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>15</u>	<u>1</u>
Other Hospital:	<u>90</u>	<u>7</u>
Office:	<u>90</u>	<u>5</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37	090
31225	Maxillectomy; without orbital exenteration	15.19	090
31360	Laryngectomy; total, without radical neck dissection	15.19	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 69155 describes a lateral temporal bone resection with a simultaneous radical neck dissection. As such, this is two procedures bundled into one. The current RVW for a complete neck dissection is 12.29 RVUs.

The median pre service time of 90 minutes for CPT Code 69155 is greater than that of the Harvard data for any of the key reference procedures. Similarly, the intra service time of 285 minutes also exceeds that of the Harvard data for any of the key reference procedures. The post service time is significant, with 30 minutes

being spent with the patient on the day of the procedure, in addition to one ICU visit of 15 minutes, 7 hospital visits totaling 90 minutes and 5 office visits totaling 90 minutes.

The otologic portion of this case involves performing a complete mastoidectomy with a facial recess approach. The tympanic membrane and external auditory canal are then removed as a unit to provide oncologic safety for this procedure. As such, this extends the normal boundaries of otologic surgery well beyond that of most operators.

Also, the radical neck dissection affords the opportunity for resection of lymphatic structures at the level of the jugular bulb. Once again, the technical skill and judgment required in performing this phase of the operation in this particular setting is greater than that which we see in a customary neck dissection.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT Code 69155 has been inappropriately undervalued due to lack of realization of the amount of work involved in all three phases of its completion. Particularly, there has been undervaluation of the intra service component of this procedure. The technical accomplishment of a neck dissection alone accompanied with a complete mastoidectomy and then enbloc resection of the tympanic membrane, tympanic bone and external auditory canal with an oncologically safe margin was not realized in the Harvard data for this procedure. Additionally, post operatively this patient faces all the risks of major operations, as is reflected in the amount of service time and number of visits which will be necessary in the 90 day global period.

Public Comments

30-Jun-95

Code: 69155

1995 RVUs: 17.03

Recommended RVUs: 40.00

Ratio:

Long Descriptor: Radical excision external auditory canal lesion; with neck dissection

Reference Set (y/n): N

Global Period: 090

Frequency: 20

Impact: 459

Source: 2

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
69155	24	8	-42.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
69155	83.3	75	-4.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
69155	otolaryngology	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
69155							
	AAOHNS	090	090	23.36	17.03	0.73	17.03

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
69155								
AAOHNS	17.03	17.03	0.73	1.00	1.00	1.00	40.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
69155								
AAOHNS	090	23.36		37		242		44

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	lcvvis	Offvis
69155									
AAOHNS		1.0	*	10	8.5		10	0.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
69155									
AAOHNS		10		40.00	17.03	ot	3		0.066

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 69554 Global Period: 090 Current RVW: 25.78 Recommended RVW: 38.00

CPT Descriptor: Excision aural glomus tumor; extended (extratemporal)

Source and Summary of Comment to HCFA on this service:
AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 33 year old female has pulsating red mass in ear. Hearing is a moderate mixed loss and she complains of pulsating tinnitus. High resolution CCT shows erosion of the jugulo-carotid spine, erosion into the descending Fallopian canal, and a non filling jugular vein and large temporal bone blush by venogram.

Description of Pre-Service Work: Review of lab. chart, radiographs. Family/patient discussion of risks, complications and alternatives. Informed consent. Shaves (2) with belly included. Sterile prep and drape. Await insertion of lines. Place cranial nerve monitoring electrodes.

Description of Intra-Service Work: Transtemporal dissection of lesion, not usually involving the labyrinth, but rather the jugular bulb, and inferior petrosal sinus. Preservation of VII while excision lesion from ossicle and middle ear sans damage to hearing. Ligation of ipsilateral jugular via neck dissection and control of sigmoid sinus just below superior petrosal sinus. Facial nerve monitoring. Closure employing abdominal wall adipose tissue.

Description of Post-Service Work: Wound dressing. Anesthetic emergence evaluation. Immediate transfer to ICU with regular neurologic checks. Operative report dictation. Progress notes and chart work. Rounds twice daily for a week (15-20 minutes each).

SURVEY DATA:

Specialty: Otolaryngology—Head and Neck Surgery

Sample Size: 49 Response Rate (%): 76.00 Median RVW: 38.00

25th Percentile RVW: 29.67 75th Percentile RVW: 50.00 Low: 20.00 High: 80.00

Median Pre-Service Time: 120 Median Intra-Service Time: 480

25th Percentile Intra-Svc Time: 360 75th Percentile Intra-Svc Time: 600 Low: 240 High: 720

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 60

ICU: 60 2

Other Hospital: 120 7

Office: 80 4

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37	090
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	23.69	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 69554 is over twice that of the most commonly referenced service - CPT Code 69642 with a current RVW of 16.37. The CPT Code 69554 in fact, was felt by our respondents to have a greater value than any of the key reference services.

This is a consistent observation in as much as the data from our survey for median pre service time, intra service time and post service time all are greater than the Harvard data for any of the key reference services.

In point of fact, CPT Code 69554 describes a much more technically difficult otologic surgical procedure than CPT Code 69642. CPT Code 69554 describes resection of a glomus tumor from the temporal bone which has extended to the extra temporal structures of the head and neck.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Using all parameters available for comparison, CPT Code 69554 uses a greater amount of time, technical skill and physical effort than any of the key reference services. The mental effort, judgment and stress involved in resecting glomus tumors which bleed quite profusely from the delicate structures about the temporal bone, middle ear and jugular bulb is considerable. The key portion of this procedure actually involves removal of the jugular bulb with the drainage of the sigmoid sinus, internal jugular vein and inferior petrosal sinus all needing to be controlled simultaneously. Significant blood loss and the range of 6 to 12 units is not unheard of.

Our respondents felt that the work involved in performing this procedure had not been captured in the initial Harvard data, which formed the basis for the current work evaluation of this procedure.

Public Comments

30-Jun-95

Code: 69554

1995 RVUs: 25.78

Recommended RVUs: 50.00

Ratio:

Long Descriptor: Excision aural glomus tumor, extended (extratemporal)

Reference Set (y/n): N

Global Period: 090

Frequency: 13

Impact: 315

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAFPRS, AAO-HNS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
69554	31	11	-39.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
69554	86.9	81.8	-2.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
69554	group practices	18.2
	otolaryngology	81.8

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
69554							
	AAOHNS	090	090	24.33	25.78	1.06	25.78

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
69554								
AAOHNS	25.78	25.78	1.06	1.00	1.00	1.00	50.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
69554								
AAOHNS	090	24.33		40	*	329		44

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
69554									
AAOHNS	*	1.0	*	10	6.0	*	10	1.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
69554									
AAOHNS	*	10		50.00	25.78	ot	3		0.053

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 69725 Global Period: 090 Current RVW: 18.98 Recommended RVW: 30.00

CPT Descriptor: Decompression facial nerve, intratemporal; including medial to geniculate ganglion

Source and Summary of Comment to HCFA on this service:

AAO-HNS

CMD

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Patient with facial paralysis due to tumor of the facial nerve, temporal bone fracture resulting in facial paralysis, idiopathic facial paralysis.

Description of Pre-Service Work: Evaluation of CT scan, MRI scan; discussion of the surgical procedures and options with the patient and family; extensive risks because of the craniotomy and risks to hearing and balance. Position, prep, drape patient. Place monitoring. Wait on insertion of lines and induction of anesthesia.

Description of Intra-Service Work: Requires microsurgery, and exposure requiring two different surgical approaches. First, mastoidectomy canal wall intact type must be performed. In addition, work must be much more precise because you need to remove bone over the fallopian canal, exposing the facial nerve without injuring the facial nerve.

Description of Post-Service Work: Patient requires Surgical Intensive Care Unit for 24 hours postop. Two visits to the Postop Intensive Care Unit is usually required. Daily visits: 15-30 minutes. 5-6 days postoperative care is required. This is similar to a comparison service of 61526.

SURVEY DATA:

Specialty: Otolaryngology—Head and Neck Surgery

Sample Size: 48 Response Rate (%): 79.00 Median RVW: 30.00

25th Percentile RVW: 23.69 75th Percentile RVW: 43.75 Low: 16.00 High: 60.00

Median Pre-Service Time: 105 Median Intra-Service Time: 275

25th Percentile Intra-Svc Time: 240 75th Percentile Intra-Svc Time: 300 Low: 180 High: 360

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>30</u>	<u>2</u>
Other Hospital:	<u>60</u>	<u>4</u>
Office:	<u>60</u>	<u>4</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37	090
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg. comminuted or involving cranial nerve foramina), multiple surgical approaches	23.69	090
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg. postfenestration)	12.41	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 69725 is a more complicated otologic microsurgical procedure than that of CPT Code 69642, which was the most frequent cited reference procedure among our survey of physicians. In fact, the respondents felt that CPT Code 69725 was approximately twice as much work as that of a tympanoplasty and mastoidectomy (CPT Code 69642). The amount of pre service time, intra service time and post service time is indeed twice that of the Harvard survey data for CPT Code 69642.

The mental effort and technical skill required to perform a decompression of the facial nerve in its intra temporal course, including the area medial to the geniculate ganglion is several levels beyond that of a straight tympanoplasty with mastoidectomy. The facial nerve has a circuitous course through the temporal bone, with two major bends in its course. The first is a greater than a right angle turn at the level of the geniculate ganglion and the second is a bend as it courses about the oval window near stapes. During this dissection, not only is the facial nerve at risk from inadvertent injury during this operation, but also, the ossicles must be protected so that inadvertent acoustic trauma to the inner ear is not transmitted.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The Harvard data upon which the current valuation of the work for CPT Code 69725 does not capture the amount of pre intra and post service work involved nor does it reflect the mental effort, judgment, technical and physical skill needed to perform this procedure. The portion of the surgery near the geniculate ganglion is particularly hazardous, due to the fact that at this point the facial nerve is in close proximity to the bony structures of the inner ear - cochlea and semicircular canals. The work involved in this procedure is clearly greater than that of a standard tympanoplasty with mastoidectomy (CPT Code 69642) due to the increased technical skill required to safely perform this procedure. There is a very real risk of permanent injury due to inadvertent damage to the patient's hearing in the cochlea and balance due to potential injury of the semicircular canals.

CMD Comments

30-Jun-95

Code: 69725

1995 RVUs: 18.98

Recommended RVUs: 21.40

Ratio: 0.13

Long Descriptor: Decompression facial nerve, intratemporal; including medial to geniculate ganglion

Reference Set (y/n): N Global Period: 090 Frequency: 13 Impact: 31.46

Source: 5 Year: 93 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
69725			
61526	REMOVAL OF BRAIN LESION	29.71	090

CMD Comment:

Should be closer to the reference CPT CODE. Much more work than 69720. RADIOLOGY A large number of suggested revisions are based upon a general overvaluation of plain film studies relative to more complex radiographic studies, ultrasound studies, and the most common CT and MRI studies. The relevant reference procedures are 70450 (revised upward), 70551, 74020, 74280, 74400, 75650, 76700, and 76805. The values listed below largely reflect differences in time and need for supervision, as well as slightly less intensity in interpretation. These services also appear markedly overvalued relative to E & M services which involve broader cognitive skills and much more time. For example, the equivalence of a level 3, 15 minute established patient visit to reading 2 1/2 chest x-rays (71020) has no face validity. A visit may involve the review of two or three radiographic studies as less than half of the work of the visit.

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AAFPRS

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
69725	15	14	-3.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
69725	66.7	85.7	9.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
69725	otolaryngology	100

Claims-Level Diagnosis Information:

Harvard Data:

CMD Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
69725							
AAOHNS		090	090	15.73	18.98	1.21	15.82
CMD		090	090	15.73	18.98	1.21	15.82

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
69725								
AAOHNS	18.98	18.98	1.01	1.20	1.00	1.00	45.00	338
CMD	18.98	18.98	1.01	1.20	1.00	1.00	21.40	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
69725								
AAOHNS	090	15.73		39	*	202		44
CMD	090	15.73		39	*	202		44

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
69725									
AAOHNS	*	1.0	*	10	2.5	*	10	0.0	5.0
CMD	*	1.0	*	10	2.5	*	10	0.0	5.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
69725									
AAOHNS	*	10		45.00	18.98	ot	3		0.054
CMD	*	10		21.40	18.98	ot	3		0.054

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 69805 Global Period: 090 Current RVW: 10.27 Recommended RVW: 15.00

CPT Descriptor: Endolymphatic sac operation; without shunt

Source and Summary of Comment to HCFA on this service:
AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman with classic Meniere's disease has disabling episodic vertigo despite appropriate medical treatment. After extensive counseling about treatment options, she undergoes an endolymphatic sac operation. After surgery she experiences some mild vertigo and fluctuation of hearing, but eventually returns to work.

Description of Pre-Service Work: Review of lab, chart, radiographs. Family/patient discussion of risks, complications and alternatives. Informed consent. Sterile prep and drape. Await insertion of lines. Place cranial nerve monitoring electrodes.

Description of Intra-Service Work: The operation is equivalent to an extended or revision mastoidectomy (69511, 69602). The surgeon must avoid entering the jugular bulb, the posterior semi-circular canal, the posterior fossa dura, or the mastoid segment of the facial nerve, all of which are at risk. Damage to the inner ear could result in permanent hearing loss or intractable dysequilibrium. These risks produce considerable psychological stress (reference mastoidectomy 69511, 69602)

Description of Post-Service Work: Take patient to recovery room, write orders, dictate or report and referral letter, talk to patient and family. Discharge instruction and summary. 3 outpatient visits on floor.

SURVEY DATA:

Specialty: Otolaryngology—Head and Neck Surgery

Sample Size: 49 Response Rate (%): 78.00 Median RVW: 15.00

25th Percentile RVW: 13.50 75th Percentile RVW: 17.00 Low: 10.00 High: 28.00

Median Pre-Service Time: 60 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 150 Low: 60 High: 210

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure: 30

ICU: 0 0

Other Hospital: 30 2

Office: 50 3

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37	090
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg. postfenestration)	12.41	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 69805 describes completion of a complete mastoidectomy with then extension of the surgical dissection posterior to the inner ear structures of the semi-circular canals to uncover the endolymphatic sac. This operation is of the same order of magnitude as the two reference services. The median pre service time of our survey for CPT Code 69805 of 60 minutes is greater than that from the Harvard data for either of the reference services. This reflects the fact that CPT Code 69805 describes a neuro otologic procedure with attendant risks to major structures in the head and neck whereas both of the reference services are used for chronic ear disease.

The median intra service time of 120 minutes is consistent with both of the Harvard data for the two reference services. The post service time again is approximately the same as the two reference services.

The mental effort and judgment, along with technical skill to required to perform CPT Code 69805 is greater than that for either 69642 or 69632.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Decompression of the endolymphatic sac is done for individuals with Meniere's Disease who have disabling vertigo despite appropriate medical management. This is a neuro otologic procedure which involves some of the techniques in skull base surgery. As such, the dissection is more extensive than that seen in either of the key reference services with potential damage to the sigmoid sinus, semicircular canals, facial nerve and posterior cranial fossa. The endolymphatic sac lies in a sheath of dura in the posterior cranial fossa, and decompression of this structure necessarily involves wide exposure of the posterior cranial fossa dura. Essentially this procedure describes a mini craniotomy to provide decompression of the endolymphatic sac.

Public Comments

30-Jun-95

Code: 69805

1995 RVUs: 10.27

Recommended RVUs: 15.00

Ratio:

Long Descriptor: Endolymphatic sac operation; without shunt

Reference Set (y/n): N

Global Period: 090

Frequency: 39

Impact: 184

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
69805	52	46	-5.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
69805	40.4	43.5	1.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
69805	group practices	4.3
	otolaryngology	95.7

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
69805							
	AAOHNS	090	090	9.69	10.27	1.06	10.27

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
69805								
AAOHNS	10.27	10.27	1.06	1.00	1.00	1.00	15.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
69805								
AAOHNS	090	9.69		24	*	92		33

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
69805									
AAOHNS	*	0.5	*	10	1.0	*	10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
69805									
AAOHNS	*	10		15.00	10.27	ot	3		0.074

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 69930 Global Period: 090 Current RVW: 14.00 Recommended RVW: 20.00

CPT Descriptor: Cochlear device implantation, with or without mastoidectomy

Source and Summary of Comment to HCFA on this service:
AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Bilateral profoundly deaf adult (18 years of age or older) or child (2 years - 18 years of age); subject does not achieve significant open-set word understanding with an appropriate hearing aid.

Description of Pre-Service Work: Requires evaluation of audiology, speech, and psychology reports; evaluation of CT scan to determine if cochlea is patent. Discussion of procedure with patient (if adult) and family or parents (if children), informed consent, selection of Cts for OR, positioning, prep, draping patient after cranial nerve monitors are placed.

Description of Intra-Service Work: Perform an intact canal wall mastoidectomy which provides entrance into the middle ear space. A cochleostomy is performed into the inner ear. A seat is drilled into the occipital cortex to provide a placement of the implanted hardware. The cochlear implant is then placed into the inner ear. This requires significant expertise to manipulate the electrode into the inner ear without damaging the electrode. The electrode is secured in the inner ear with a fascia patch. Electrodes are secured to the mastoid cortex and then electrophysiologic testing of the implant is performed following suturing of the wound closure.

Description of Post-Service Work: Dictation of the operative report, letter, writing order, talking to patient and family. The postoperative care requires changing the mastoid dressing and removing the drain on the first or second postoperative day, rounding on the patient approximately four times while the patient is in the hospital, and removal of stitches approximately one week after the procedure is performed. This is similar to an intact canal wall or revision mastoid surgery. The patient then returns one month following implantation for programming of the speech processor. This requires six to eight hours of time in an adult and 16 to 36 hours in a child. In comparison to the reference, time commitment is much more extensive than a revision mastoidectomy because of the speech processor programming.

SURVEY DATA:

Specialty: Otolaryngology—Head and Neck Surgery

Sample Size: 49 Response Rate (%): 76.00 Median RVW: 20.00

25th Percentile RVW: 18.00 75th Percentile RVW: 22.47 Low: 13.00 High: 33.50

Median Pre-Service Time: 120 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 173 75th Percentile Intra-Svc Time: 240 Low: 80 High: 300

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>30</u>	<u>2</u>
Office:	<u>60</u>	<u>3</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37	090
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material	11.64	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The surgeons responding to this code felt that a cochlear implant was a service significantly valued greater than that of most cited reference service 69642, which is a tympanoplasty and mastoidectomy. A number of responders commented that placement of a cochlear implant is impossible without a mastoidectomy. In point of fact, the only individuals where a "mastoidectomy" would not be done, are those persons who have had this surgery previously.

The description of the pre service and intra service is greater than that for any of the key reference services. The post service time is significant for this procedure and is in keeping with the key reference services Harvard data.

The degree of technical skill required to accurately isolate the round window in the middle ear, and then to manipulate a micro electrode into cochlea is considerable. This micro electrode must pass through the two and one half turns of the cochlea in a space which is barely adequate to accommodate the diameter of the micro electrode. Neither the cochlea nor the electrode may be damaged during this procedure or the cochlear implant will fail.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The responders to our survey all felt that placement of a cochlear implant was greater work than that of any of the key reference services. In particular, the degree of mental effort, skill and judgment necessary to place the micro electrode within the two and a half turns of the cochlea in the inner ear, was significantly greater than the work involved in CPT Code 69642. In addition, this code requires preparation of a formal skin flap to provide coverage of the internal electronic devices necessary to allow the cochlear implant to work. If there is any failure in this portion of the operation, the device becomes exposed to the skin and will require removal. The opening into the inner ear is quite small, and is usually accomplished through a facial recess approach. This exposure is quite limited and can only be accomplished with a high degree of technical skill using micro surgical techniques similar to skull base surgery.

Public Comments

30-Jun-95

Code: 69930

1995 RVUs: 14

Recommended RVUs: 20.00

Ratio:

Long Descriptor: Cochlear device implantation, with or without mastoidectomy

Reference Set (y/n): N

Global Period: 090

Frequency: 137

Impact: 822

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
69930	0	0	50	0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
69930	188	156	-8.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
69930	48.4	48.7	0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
69930	audiologist	5.1
	group practices	12.8
	otolaryngology	80.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
69930	387	6.3	OTOSCLEROSIS
	389	25	HEARING LOSS
	V45	6.3	OTHER POSTSURGICAL STATES

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
69930							
AAOHNS		090	090	13.48	14.00	1.04	14.00

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
69930								
AAOHNS	14.00	14.00	1.04	1.00	1.00	1.00	20.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
69930								
AAOHNS	090	13.48		30	*	156		36

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
69930									
AAOHNS	*	0.5	*	10	1.0	*	10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
69930									
AAOHNS	*	10		20.00	14.00	ot	n		0.065

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 69950 Global Period: 090 Current RVW: 21.15 Recommended RVW: 28.00

CPT Descriptor: Vestibular nerve section, transcranial approach

Source and Summary of Comment to HCFA on this service:
AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Patient with recurring spells of vertigo refractory to medical management. Patient has usually had psychological evaluation.

Description of Pre-Service Work: Review of peripheral vestibular system work-up including ENG, audiogram, MRI and CT scan evaluations; discussion of procedure with patient and family, informed consent, positioning, prepping, draping patient after placing cranial nerve monitors.

Description of Intra-Service Work: Requires slightly less time than the reference acoustic tumor excision, but same critical tolerance and microsurgical skills required; must preserve hearing; similar to a middle fossa facial nerve decompression.

Description of Post-Service Work: Take patient to recovery room, dictate letter and OR report, write orders, talk to patient and family. Requires visits to the Intensive Care Unit immediately postop x 2 day; 5-7 days, dependent upon vestibular compensation.

SURVEY DATA:

Specialty: Otolaryngology—Head and Neck Surgery

Sample Size: 49 Response Rate (%): 80.00 Median RVW: 28.00

25th Percentile RVW: 23.85 75th Percentile RVW: 32.72 Low: 10.00 High: 60.00

Median Pre-Service Time: 120 Median Intra-Service Time: 210

25th Percentile Intra-Svc Time: 180 75th Percentile Intra-Svc Time: 240 Low: 30 High: 360

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>30</u>	<u>2</u>
Other Hospital:	<u>82.5</u>	<u>5</u>
Office:	<u>60</u>	<u>3</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37	090
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg. comminuted or involving cranial nerve foramina), multiple surgical approaches	23.69	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 69950, vestibular nerve section using a transcranial approach is a neurosurgical approach to the vestibular nerve through the middle cranial fossa requiring critical tolerance and micro surgical skills.

The median pre service time of our survey of 120 minutes is greater of that of any of the key references. Similarly, the intra service of 210 minutes from our survey is more extensive than an of the key reference services Harvard data.

The post operative phase of this procedure is much more extensive than any of the key reference services due to the fact that this is a formal craniotomy and will require at least an overnight stay in the intensive care unit for observation of bleeding, cranial nerve deficits or change in sensorium.

The respondees felt that the value of CPT Code 69950 should be approximately twice that of the most frequently sighted reference procedure 69642-tympanoplasty with mastoidectomy.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A sectioning of the vestibular nerve through a transcranial approach is a formal craniectomy with exposure of the middle cranial fossa and dissection along the "roof" of the temporal bone. To accurately isolate the vestibular nerve, one must have considerable microsurgical skills. The vestibular nerve lies between the cochlea and the semicircular canals. In this position, there is a real chance of inadvertent injury to the cochlear semicircular canals with concomitant permanent sensorineural hearing loss or continued vertigo. Inasmuch as the procedure is being done for patients with intractable vertigo, this particular complication is catastrophic. The degree of mental stress, and technical skill required to accomplish and is reflected in the survey data collected from the body of neuro-otologists and otologists in the AAO-HNS instrument.

Public Comments

30-Jun-95

Code: 69950

1995 RVUs: 21.15

Recommended RVUs: 32.00

Ratio:

Long Descriptor: Vestibular nerve section, transcranial approach

Reference Set (y/n): N

Global Period: 090

Frequency: 19

Impact: 206

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
69950	0	0	0	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
69950	29	27	-3.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
69950	93.1	85.2	-3.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
69950	neurological surgery	22.2
	otolaryngology	77.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
69950	386	25	VERTIGINOUS SYNDROMES AND OTHER

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
69950	,						

Public Comments

30-Jun-95

AAOHNS	090	090	20.22	21.15	1.05	21.15
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Harvard Data:

Comm	Mswk93	Mfewk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
69950								
AAOHNS	21.15	21.15	1.05	1.00	1.00	1.00	32.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
69950								
AAOHNS	090	20.22		33	*	184		42

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	lcuvis	Offvis
69950									
AAOHNS	*	1.0	*	10	4.0	*	10	1.3	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
69950									
AAOHNS	*	10		32.00	21.15	ot	3		0.080

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 69955 Global Period: 090 Current RVW: 22.12 Recommended RVW: 30.00

CPT Descriptor: Total facial nerve decompression and/or repair (may include graft)

Source and Summary of Comment to HCFA on this service:
AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Patient with tumor of facial nerve or skull base requiring removal of the VIIth nerve and grafting or decompression of the VII nerve.

Description of Pre-Service Work: Evaluation of the CT and MRI scan, lab data, chart; explanation of surgical procedure, informal consent, positioning, prepping and draping patient right after placement of cranial nerve monitors.

Description of Intra-Service Work: Five to six hours of the time is microsurgical, middle fossa craniotomy, mastoidectomy, lateral lobe parotidectomy with facial nerve preservation, harvest of the sural nerve graft, microsurgical anastomosis of facial nerve in brainstem to the facial nerve in the parotid gland. Requires extensive expertise and microsurgical skill.

Description of Post-Service Work: The patient is in the Intensive Care Unit for approximately 24 hours postoperative. Dressing changes in patient bed 5-7 days.

SURVEY DATA:

Specialty: Otolaryngology—Head and Neck Surgery

Sample Size: 48 Response Rate (%): 77.00 Median RVW: 30.00

25th Percentile RVW: 24.00 75th Percentile RVW: 45.00 Low: 18.00 High: 72.00

Median Pre-Service Time: 120 Median Intra-Service Time: 300

25th Percentile Intra-Svc Time: 300 75th Percentile Intra-Svc Time: 360 Low: 180 High: 600

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>40</u>	<u>2</u>
Other Hospital:	<u>65</u>	<u>5</u>
Office:	<u>60</u>	<u>4</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37	090
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg. comminuted or involving cranial nerve foramina), multiple surgical approaches	23.69	090
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	18.63	090
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	12.41	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 69955 requires a greater expenditure of time and effort than any of the key reference services. This is reflected in the median pre service time of 120 minutes from our survey data compared to the Harvard information for any of the reference services. In fact, this is greater than twice the amount of effort noted in any of these services.

The median intra service time of 300 minutes is reflective of the extent of this operation. There is a need for both a middle cranial fossa approach (CPT Code 69950 current RVU 21.15) along with a complete mastoidectomy and decompression of the facial nerve (CPT Code 69725 current RVW 18.98). This is necessary due to the fact that the facial nerve has the most tortuous bony course of any cranial nerve. There are two major bends in the facial nerve - one at the geniculate ganglion and another as the facial nerve rounds the oval window. This is considerably greater technical expertise than is required for any of the key reference services.

The post operative phase is similarly extensive reflecting the fact that the patients undergoing CPT Code 69955 are routinely placed in the intensive care unit for observation of intracranial bleeding, change in sensorium or cranial neuropathies.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT Code 69955 describes an extensive surgical procedure involving the middle cranial fossa, as well as the mastoid. This extensive procedure to decompress the entire facial nerve is necessary due to the circuitous route which the facial nerve takes through the temporal bone. The degree of clinical skill, judgment and stress involved in this procedure is among the greatest in all of micro neurosurgery. This procedure can be justifiably classified as a skull base operation.

In addition, should the facial nerve require more than a decompression, the code involves repair of the facial nerve with or without a facial nerve graft. This again adds additional time and technical expertise to this procedure. In some instances, the facial nerve may need to be anastomosed at the level of the brain stem. This procedure requires extensive expertise and micro-surgical skills. Current RVW, derived from Harvard data, does not capture the intensity or degree of technical skill required for this procedure.

Public Comments

30-Jun-95

Code: 69955

1995 RVUs: 22.12

Recommended RVUs: 50.00

Ratio:

Long Descriptor: Total facial nerve decompression and/or repair (may include graft)

Reference Set (y/n): N

Global Period: 090

Frequency: 13

Impact: 362

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
69955	0	0	0	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
69955	23	18	-10.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
69955	82.2	50	-16.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
69955	neurological surgery	5.6
	other nonphysician prov	11.1
	otolaryngology	83.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
69955	351	25	FACIAL NERVE DISORDERS
	383	25	MASTOIDITIS AND RELATED CONDITIO

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
69955							
AAOHNS		090	090	22.17	22.12	1.00	22.12

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
69955								
AAOHNS	22.12	22.12	1.00	1.00	1.00	1.00	50.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
69955								
AAOHNS	090	22.17		43	*	244		46

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
69955									
AAOHNS	*	1.0	*	10	5.0	*	10	1.3	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
69955									
AAOHNS	*	10		50.00	22.12	ot	3		0.066

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 69960 Global Period: 090 Current RVW: 19.75 Recommended RVW: 30.00

CPT Descriptor: Decompression internal auditory canal

Source and Summary of Comment to HCFA on this service: AAO-HNS

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient who has progressive neuropathway hearing loss and/or vestibular symptoms. The findings by high resolution CT scan and MRI indicate a restriction of the internal auditory canal space either by new bone formation, soft tissue mass, excluding an acoustic schwannoma, and inclusive of cholesteatoma, metastatic tumor, inflammatory lesion or traumatic lesion.

Description of Pre-Service Work: This is a rare situation and finding in medicine and requires a high degree of mental effort and judgment. The potential for making the patient worse is high if the diagnosis is not correct. It is an area of subspecialization and requires special training in otology. Determination of the specific lesion requires a broad survey of medicine and a very specific understanding of lesions of the temporal bone. Requires great technical skill and physical effort. Psychological stress is high. Prognosis is poor and outcome is very dependent upon extraordinary skill and judgment. Review lab data, chart, CT, MRI, discuss procedure with patient and family, get informed consent; position, prep and drape patient after placement of cranial nerve monitors.

Description of Intra-Service Work: The incision for such an operation is made just superior to the auricle. The squamous portion of the temporal bone is removed in a fashion analogous to a craniectomy to provide exposure to the middle cranial fossa. The temporal lobe of the brain is elevated and the superior surface of the temporal bone is exposed.

Using standard landmarks, the internal auditory canal is identified. The margin for error in this portion of the dissection is in fractions of millimeters. The bone of the superior surface of the temporal bone must be removed without entering the cochlea or the semicircular canals of the inner ear. This dissection would not be performed by residents, but rather is the subject of fellowship training.

Any work on the internal auditory canal must avoid injury to the facial nerve which is intimately adherent to the acoustic and vestibular portions of the eighth cranial nerve.

The wound is closed and the patient is taken to the intensive care unit.

Description of Post-Service Work: Take patient to recovery room, write orders, dictate referral letter and OR report, talk to patient and family. The patient will be in an intensive care setting for one to two days. All the precautions and observations necessary for neurosurgical procedures will be followed. The patient will be examined twice per day for 30 minutes each visit during this time.

The patient will be transferred to the floor where a similar pattern of visits will continue, except that they will not be as intense.

SURVEY DATA:Specialty: Otolaryngology—Head and Neck SurgerySample Size: 49 Response Rate (%): 63.00 Median RVW: 30.0025th Percentile RVW: 23.00 75th Percentile RVW: 36.50 Low: 18.00 High: 55.00Median Pre-Service Time: 100 Median Intra-Service Time: 24025th Percentile Intra-Svc Time: 205 75th Percentile Intra-Svc Time: 300 Low: 100 High: 600

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>40</u>	<u>2</u>
Other Hospital:	<u>60</u>	<u>5</u>
Office:	<u>60</u>	<u>4</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37	090
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	12.41	090
42420	Excision of parotid tumor or parotid gland: total, with dissection and preservation of facial nerve	18.63	090
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	23.69	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 69960 was felt by our respondents to be significantly more work than any of the reference procedures. In fact, with the exception of CPT Code 21433, the degree of work, mental effort and stress was felt to be twice that of most of the reference procedures.

This is reflected in the median pre-service time of our survey for CPT Codes 69960 being 100 minutes with a median intra service time of 240 minutes. Again, this is greater than the Harvard data for any of the reference services.

The amount of post service work is extensive in this procedure, reflecting the fact that a middle cranial fossa approach is necessary to provide decompression of the internal auditory nerve. This procedure requires a high degree of technical skill and is similar to CPT Code 69950, which is a transcranial approach to the vestibular nerve which has a current RVU of 21.15, and a recommended RVW of 28.00.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Decompression of the internal auditory canal is an infrequent procedure performed only by those most expert in micro-surgical techniques of the temporal bone. This is a formal middle cranial fossa approach to the internal auditory canal and requires the surgeon to avoid inadvertent injury to the cochlea or the semi-circular canals. The blood vessels in the posterior cranial fossa and middle fossa are at risk and must be protected. Inadvertent injury to one of these small vessels could cause a brain stem infarction. The surgeon must also take care to avoid injuring the facial nerve which is intimately adherent to the eighth cranial nerve.

Postoperatively, this patient receives the same type of care as an individual undergoing a formal neuro-surgical procedure. This can be considered skull base surgery. The Harvard valuation of this service does not recognize the skill, expertise, mental stress and effort required to perform this procedure.

Public Comments

30-Jun-95

Code: 69960

1995 RVUs: 19.75

Recommended RVUs: 40.00

Ratio:

Long Descriptor: Decompression internal auditory canal

Reference Set (y/n): N

Global Period: 090

Frequency: 19

Impact: 385

Source: 4

Year: 93

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
69960	17	23	18.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
69960	69.7	100	15.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
69960	otolaryngology	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
69960							
AAOHNS		090	090	19.71	19.75	1.00	19.75

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
69960								
AAOHNS	19.75	19.75	1.00	1.00	1.00	1.00	40.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
69960								
AAOHNS	090	19.71		33	*	186		42

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
69960									
AAOHNS	*	1.0	*	10	4.0	*	12	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
69960									
AAOHNS	*	10		40.00	19.75	ot	3		0.079

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 69970 Global Period: 090 Current RVW: 22.30 Recommended RVW: 32.70

CPT Descriptor: Removal of tumor, temporal bone

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Patient would have symptoms and signs of dysfunction of the neural and vascular components of the temporal bone such as hearing loss, vestibular symptoms, facial nerve paralysis. These symptoms and signs would be documented by clinical findings, physical examination and imaging studies. The CT scan and MRI are suggestive of an acoustic nerve tumor.

Description of Pre-Service Work: Review MRI, CT, lab data, chart, audiogram, ENG. Talk to patient and family. Get informed consent. Position, prep, drape patient after placement cranial nerve monitors and vascular lines.

Description of Intra-Service Work: Removal of a tumor of the temporal bone is one of the most challenging operations in otolaryngology. This requires skill and knowledge of the three-dimensional anatomy of the temporal bone and its relationships to the brain, internal carotid artery, sigmoid sinus and jugular bulb as well as an appreciation of the need to accomplish a satisfactory tumor removal.

The tumor is approached by a combination of preliminary mastoid surgery to isolate the structures of the middle ear and mastoid, preparatory neck surgery to expose the great vessels and cranial nerves and exposure through a temporal craniectomy for protection of the brain.

The tumor and temporal bone are dissected en bloc. A high degree of skill is needed to isolate the structures which will need to be saved and at the same time remove the tumor in a satisfactory fashion. In every sense of the word, this is skull base surgery.

Following tumor removal, the surgeon must reconstruct the wound (separate code). This will most commonly require a free flap for reconstruction.

The most analogous code with which to compare the intraoperative work is CPT 61530 at 42.35 RVU's.

Description of Post-Service Work: ICU x 2 - 3 days. Inpatient days 4 - 7.

SURVEY DATA:

Specialty: American Academy of Otolaryngology—Head and Neck Surgery

Sample Size: 48 Response Rate (%): 77.00 Median RVW: 32.70

25th Percentile RVW: 27.50 75th Percentile RVW: 40.92 Low: 20.00 High: 72.00

Median Pre-Service Time: 120 Median Intra-Service Time: 33025th Percentile Intra-Svc Time: 270 75th Percentile Intra-Svc Time: 420 Low: 180 High: 720

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>52.5</u>	
ICU:	<u>30</u>	<u>2</u>
Other Hospital:	<u>70</u>	<u>5</u>
Office:	<u>60</u>	<u>3.5</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	16.37	090
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve.	18.63	090
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	23.69	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code 69970 describes a temporal bone resection which is most commonly done for epidermoid carcinoma of the temporal bone. This is one of the most challenging and difficult operations in otolaryngology. Before the advent of modern micro-surgical techniques and skull base surgery, this procedure enjoyed a nearly 50% mortality. Particularly difficult was the handling of the internal carotid artery at the depths of the wound.

The respondees to our survey for CPT Code 69970 felt that this procedure was significantly more difficult than any of the key reference procedures. This is reflected in the median pre service time of our survey of 120 minutes, which is greater than the Harvard data for any of the reference codes. Similarly, the intra service time of 330 minutes is also more extensive than that of any of the reference services by nearly 2 times. Lastly, the median post service time of this procedure reflects the degree of complexity and potential injury to key structures of the brain, carotid artery, facial nerve, jugular venous system and the very real potential for catastrophic infectious problems.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

CPT Code 69970 is among the most difficult procedures in all of otolaryngology - head and neck surgery. The degree of skill required to encompass the temporal bone and its relationships to the rest of the skull is considerable. This procedure will require a complete mastoidectomy, middle cranial fossa approach to the superior aspect of the temporal bone, dissection of the structures inferior to the temporal bone at the base of the skull and then appropriate handling of the anterior structures of the temporal bone as they relate to the mandible and parotid gland. This procedure is effective in treating cancer of the ear and temporal bone, but requires considerable skill and expertise on the part of the surgeon. This is a skull base operation with the attendant risks of death, stroke, blindness or significant intra-cranial injury, in addition to the potential for catastrophic infectious complications. The Harvard survey data upon which the current RVU is based, does not capture this scope of the difficulty required in this operation. The degree of technical skill, mental stress and effort are all considerable and are more accurately realized in the AAO-HNS survey of surgeons actively performing this operation.

Public Comments

30-Jun-95

Code: 69970

1995 RVUs: 22.3

Recommended RVUs: 45.00

Ratio:

Long Descriptor: Removal of tumor, temporal bone

Reference Set (y/n): N

Global Period: 090

Frequency: 48

Impact: 1090

Source: 1

Year: 92

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
69970	100	0	0	0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
69970	57	53	-3.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
69970	82.5	84.9	1.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
69970	group practices	7.5
	neurological surgery	3.8
	otolaryngology	88.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
69970	213	25	BENIGN NEOPLASM OF BONE AND ARTI

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
69970							
AAOHNS		090	090	21.50	22.30	1.04	22.30

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
69970								
AAOHNS	22.30	22.30	1.04	1.00	1.00	1.00	45.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
69970								
AAOHNS	090	21.50		36	*	250		43

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
69970									
AAOHNS	*	1.0	*	10	6.0	*	10	1.2	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
69970									
AAOHNS	*	10		45.00	22.30	ot	3		0.059

RUC Five Year Review
Recommendations

DATE

Volume 2

1995

1995

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE YEAR REVIEW OF THE RBRVS
RECOMMENDATIONS

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**AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Cardiothoracic and Vascular Surgery

Comments were submitted by the American Society of General Surgeons (ASGS) and the Society of Thoracic Surgeons (STS) stating that lung procedures were not appropriately valued in the Harvard RBRVS study. In particular, comments noted that pre- and postservice times had been estimated by Harvard rather than directly measured and that the current RVUs do not reflect the physician work involved in: (1) maintaining proper hemodynamics during initiation of anesthesia, (2) stabilizing the patient for transfer to the recovery room, and (3) accumulating sufficient evidence that immediate reoperation or other intervention for bleeding, impaired circulation, or air leak is not needed. The STS also commented on several cardiac operations which it believes have become more complex over time, and recommended slight increases in 11 CABG procedures. The RUC did not believe that sufficiently compelling evidence was provided to support increases in the RVUs for thoracic procedures because most of these services have already been reviewed by the RUC, and any changes in work since the Harvard study should have been reflected in the RUC's 1993 recommendations. The RUC agreed that increases were warranted in two of the cardiac surgery procedures, mitral valve repair with prosthetic ring (33426) and descending thoracic aorta graft (33875), which have become more complex over the last five years.

The comments submitted by the International Society for Cardiovascular Surgery/The Society for Vascular Surgery (SVS) described a number of problems in the current RBRVS for vascular surgery procedures, many of which are due to the lack of any distinct study of vascular surgical procedures or vascular surgeons in the Harvard RBRVS study. This omission could have particularly deleterious effects for the Medicare program because Medicare patients account for an exceptionally high percentage of total patients seen by vascular surgeons. The comment notes, for example, that no vascular surgeons were included in the Harvard Technical Consulting Groups. It also describes errors in the Harvard vignettes, which could have resulted from the absence of vascular surgeons on the Harvard TCGs and led to incorrect data. The comment also notes that some adjustments were made in these services for the 1993 RBRVS based on an Abt study, but that further refinements are needed. Finally, the comments report the results of an effort to obtain intraoperative times from 10 hospitals for nine vascular procedures and eleven other codes selected from the Multispecialty Points of Comparison (MPC). This study found that, while data on nonvascular codes corresponded closely to existing Harvard and RUC data for the services, for vascular surgical codes the current data were 20% lower than the hospital reported times. The ASGS also commented on two vascular surgical procedures, code 34201 for femoropopliteal embolectomy or thrombectomy and code 35654 for axillary-femoral-femoral bypass graft, with other than vein.

The RUC found that the arguments presents by the SVS presented a compelling reason to review the current RVUs for selected vascular surgery procedures. It did not adopt the particular approaches or proposed RVUs recommended by the SVS, however. The alternative methods used to calculate the RUC-recommended RVUs are described below.

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Comments were received from the Society of Cardiovascular and Interventional Radiology (SCVIR), the American College of Surgeons (ACS), the American Society of Hematology (ASH), the American Thoracic Society (ATS), and the SVS and ASGS regarding nine other cardiovascular procedures. The RUC agreed with the SCVIR that there are anomalies in the current RVUs for codes 36215, 36218, 36245, and 36248. It is recommending a work neutral adjustment in the current RVUs for 36215 and 36245 to make them equal and is recommending a global period change for codes 36218 and 36248. The RUC adopted the increase recommended by the general and vascular surgeons for code 36830 for creation of arteriovenous fistula. For the remainder of the codes in this group, the RUC did not believe sufficient evidence was presented to support an increase and is recommending that the current RVUs be maintained.

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
Thoracic Surgery						
32000	Drainage of chest	1.54	1.54	The Mayo Foundation commented that the work involved in thoracentesis is equivalent to tube thoracostomy (code 32020) because the intraservice times are equivalent.	None of the specialties on the RUC Advisory Committee elected to develop evidence supporting this contention, but data from the Harvard RBRVS study suggests tube thoracostomy requires more postservice work and time than thoracentesis. The RUC recommends maintaining the current RVUs.	2
32020	Insertion of chest tube	3.98	3.98	ASGS commented that the RVUs for tube thoracostomy should be increased from 3.98 to 4.94.	An Abt study for the ACS suggests the current RVUs are appropriate. The ASGS elected not to develop additional supporting evidence and the RUC recommends maintaining the current RVUs.	2
32100	Exploration/biopsy of chest	10.07	10.07	The STS and ASGS presented data on intraservice times for large numbers of patients who underwent thoracotomy (32100), pneumonectomy (32440), lobectomy (32480), and pulmonary wedge resection (32500), which suggested that the intraservice time assumptions underlying the current RVUs are too low.	A survey confirmed the STS comments that the intraservice times may be longer than the Harvard data suggest and that the recommended increases would make the services more appropriate in comparison to other codes in the family. The RUC recommends that the current RVUs be maintained, however, because they are based on recommendations made by the RUC and adopted by HCFA in 1993. Although the specialties provided ample evidence about the complexity of the services, they did not provide a compelling argument that the work had increased in the past two years.	2
32440	Removal of lung	19.15	19.15			2
32480	Partial removal of lung	16.84	16.84			2
32500	Partial removal of lung	13.10	13.10			2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
32602	Thoracoscopy, diagnostic	5.96	5.96	The ASGS recommended that the RVUs for diagnostic thoracoscopy be increased from 5.96 to 11.81.	The current RVUs are based on a RUC recommendation. The RUC did not wish to revisit its previous recommendation and the ASGS elected not to develop and present additional evidence to support this comment. The RUC recommends maintaining the current RVUs.	2
Cardiac Surgery						
33010	Drainage of heart sac	2.24	2.24	Comments were submitted by an individual recommending that the RVUs be increased from 2.24 to 6.00.	None of the specialties on the RUC Advisory Committee elected to develop further evidence supporting this comment, and the RUC did not find the argument a convincing one.	2
33208	Insertion of heart pacemaker	7.28	7.28	The ASGS recommended the RVUs for pacemaker insertion or replacement be increased from 7.28 to 8.76.	The CPT codes for pacemaker services were recently reviewed by the RUC and neither the ASGS nor any of the other specialty societies pursued development of additional support for a change in the current RVUs.	2
33244	Remove generator	8.34	8.34	The American College of Cardiology recommended that the RVUs for 33244 be increased to 12.00.	The current RVUs for 33244 are based on recent recommendations from the RUC. No compelling evidence was presented to support another review of this code.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
33425	Repair of mitral valve	25.57	25.57	The STS recommended an increase in the RVUs for mitral valve repair (33425) from 25.57 to 29.42, for mitral valve repair with prosthetic ring (33426) from 26.07 to 29.42, and for mitral valve repair involving radical reconstruction with or without ring (33427) from 32.07 to 35.00. The STS described the work involved in codes 33245 and 33246 as being equivalent to mitral valve replacement (code 33430, 29.42 RVUs).	After in-depth study, the STS concluded that the current RVUs for codes 33425 and 33427 should be maintained and the RUC agreed. The RUC recommends that the RVUs for 33426 be increased to equal the RVUs for 33430. Patients are more complex because those with mitral valve prolapse advancing to mitral regurgitation are surviving to an older age with medical management, with nearly half of Medicare patients aged 75 or older. Many of these patients have more advanced mitral regurgitation and present greater surgical challenges. The procedure is also being used for patients with mitral insufficiency. Also, whereas surgeons previously may have replaced the mitral valve with a prosthetic valve, they now attempt to reconstruct more valves because this is a safer option for patients. Such reconstruction may require insertion of a prosthetic ring in the dilated annulus, which is almost as much work as suturing in a prosthetic valve. A survey found that the code should actually be valued slightly higher than 33430, but the RUC did not find the survey data as compelling as the argument that the two codes should have equal work values.	2
33426	Repair of mitral valve	26.07	29.42			4
33427	Repair of mitral valve	32.07	32.07			2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
33510	CABG, vein, single	23.29	23.29	The STS commented that, in the process of developing the practice expense RVUs for these codes when they were revised in 1993, HCFA made adjustments in the work RVUs which sharply reduced the RUC-recommended differential between the arterial and venous codes to 0.72 rather than 2.18. The comment requested a technical correction.	HCFA can determine if a "technical correction" is warranted. As the comment notes, the CPT codes for CABG procedures were changed in 1993 and the RUC reviewed the RVUs for these services at that time. For 8 of the 10 codes, the requested increase is less than 10% of the current RVUs, and the RUC does not believe the survey process is sufficiently precise to validate such small changes through a new survey of work, so if the issue involves more than a technical correction, the RUC recommends the current RVUs be maintained.	2
33511	CABG, vein, two	25.57	25.57			2
33512	CABG, vein, three	27.84	27.84			2
33513	CABG, vein, four	30.12	30.12			2
33514	CABG, vein, five	32.39	32.39			2
33516	CABG, vein, six+	34.66	34.66			2
33533	CABG, arterial, single	24.00	24.00			2
33534	CABG, arterial, two	26.99	26.99			2
33535	CABG, arterial, three	26.98	26.98			2
33536	CABG, arterial, four+	32.96	32.96			2
33530	Coronary artery, bypass/reop	5.86	5.86	Comments stated the RVUs for CABG reoperation should reflect the higher likelihood of major intra- and postoperative complications compared to a primary CABG operation. The transverse aortic arch graft was described as the most challenging cardiovascular procedure performed today, and an increase to 49.91 RVUs was recommended.	The STS stated it was withdrawing codes 33530 and 33870 as it was unable to gather sufficient evidence to support the change. The RUC recommends that the current RVUs be maintained.	2
33870	Transverse aortic arch graft	37.74	37.74			2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
33875	Thoracic aorta graft	26.94	31.23	Comments stated the work involved in descending thoracic aorta graft has increased over time as the procedure is now performed almost invariably with bypass, although the code descriptor states "with or without bypass." An increase was recommended from 26.94 to 31.23 RVUs to make it equivalent to ascending aorta graft, a code which is also performed invariably with bypass.	A survey confirmed that the work of this service is equal to ascending aorta graft. Patients must be managed under both hypothermia and cardiopulmonary bypass, and the procedure entails risks of further aortic dissection and heavy bleeding. The RUC also noted that a high proportion of patients are African-Americans who are likely to have high blood pressure, renal disease, and other conditions which add to the procedure's complexity. Use of bypass is now the standard of care, which adds the time to put the patient on bypass and converts the service from a closed to an open heart procedure. In comparing 33875 to 33860, the greatest work difference is in the dissection, particularly since 33875 can cause paralysis in the patient, which is not a risk in 33860. The RUC recommends 33875 be increased as recommended.	1
Vascular Surgery						
34201	Removal of artery clot	8.04	8.04	The ASGS recommended an increase from 8.04 to 12.59 RVUs.	No survey was conducted of vascular surgeons' work for this service, and the RUC did not feel sufficient rationale or evidence was provided to support a change from the current RVUs.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
35081	Repair defect of artery	22.15	26.23	As noted above, SVS comments described problems in the current RBRVS for vascular surgery procedures, mainly due to the lack of any distinct study of vascular surgical procedures or vascular surgeons in the Harvard RBRVS study. Intraoperative times were obtained from 10 hospitals for nine vascular procedures.	<p>The RUC found that the SVS comments constituted a compelling reason to review and revalue the codes addressed in their comments. They did not agree, however, with the specific approaches used by the SVS to develop new proposed values.</p> <p>The RUC recommends an increase to 26.23 RVUs for 35081 based on the evidence gathered by the SVS, which showed that the 167 minutes of intraservice time from the Harvard study was 35 minutes too short, the preoperative time was 40 minutes too short, and the IWPOT of 0.074 was too low:</p> <ul style="list-style-type: none"> ●The sum of (1) the additional intraoperative time of 35 minutes at 0.08 per minute and (2) increasing the 167 minutes from the Harvard study from .074 to .08 per minute added 3.80 additional RVUs for intraservice work. ●The 40 additional minutes of preservice time at 0.028 units per minute added 1.00 RVUs for preservice work. ●Adding 3.80 and 1.00 to the Harvard RVUs of 21.31 produced the recommended RVUs of 26.23, which is lower than the 28.50 RVUs recommended by the SVS. 	4
35082	Repair artery rupture, aorta	28.82	34.20		<p>The RUC recommends an increase to 34.20 RVUs, which would maintain the current relationship between codes 35081 and 35082 (35082 is 30% higher than 35081), and which is lower than the 37.00 RVUs recommended by the SVS.</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
35091	Repair defect of artery	28.10	33.16	See summary of SVS comment on previous page.	The RUC recommends an increase to 33.16 RVUs, which would maintain the current relationship between codes 35081 and 35091, and which is lower than the 36.50 RVUs recommended by the SVS.	4
35102	Repair defect of artery	23.44	28.80		The RUC considered the relationship between the SVS survey medians for codes 35081 and 35102 to be more appropriate than the ratio of the current RVUs for the codes. The SVS survey median for code 35102 was 30.74, and for code 35081 was 28.00. To calculate the recommended RVUs of 28.80 for 35102, the recommended RVUs of 26.23 for 35081 were multiplied by the ratio of the two survey medians. The SVS had originally recommended 31.50 RVUs for this service.	4
35301	Rechanneling of artery	15.95	17.79		The RUC recommendation for 35301 is based on data gathered by the SVS that it involves 143 minutes of intraoperative work rather than the two hours identified by the Harvard study. Valuing the additional 23 minutes at 0.08 IWPUT produced a new value of 17.79 RVUs.	4

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
35556	Artery bypass graft	15.47	19.37	See summary of SVS comments on p. 7.	<p>The RUC recommendations for these codes recognize the additional work involved in 35556 that is not recognized in the current RVUs, correct a rank order anomaly that currently exists between codes 35566 and 35585, and establish correct relationships between bypasses with vein and bypasses with in-situ vein. The SVS survey demonstrated that the current RVUs significantly underestimate the work involved in 35556. With a slight reduction to preserve a previous adjustment for work neutrality that was made in this family of codes, the increment of work between codes 35566 [<i>Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels</i>] and 35666 [<i>Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery</i>] was added to the current RVUs of 15.47 for code 35556 [<i>Bypass graft, with vein; femoral-popliteal</i>]. The recommended RVUs for code 35583 [<i>In-situ vein bypass; femoral-popliteal</i>] are 3% higher than 35556, as they are currently. The current relationship between the femoral-popliteal and femoral-anterior tibial services is preserved in recommended increase for code 35566 from 20.21 to 24.45 RVUs. The recommended RVUs for code 35585 [<i>In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery</i>] are 6% higher than code 35566, rather than 6% lower as they are now. The current relationship between codes 35556 and 35656 [<i>Bypass graft, with other than vein; femoral-popliteal</i>] is also preserved in the recommended RVUs. The RUC-recommended values for these services are all lower than those proposed by the SVS.</p> <p>The newer, in-situ procedures involve somewhat more work than the older procedures because, instead of the vein being removed from its location and reversed, the incision is made along the entire length of the vein, the branches are tied off, and the two ends are freed up and sewn to the nearby artery. Since the veins have not been reversed, this leaves the problem of the one-way valves, which must then be mechanically disrupted to allow blood to flow through the conduit. Any false move with the valvutome can rip a huge hole in the vein, but publications suggest improved long-term graft patency when this in-situ technique is used.</p>	4
35566	Artery bypass graft	20.21	24.45			4
35583	Vein bypass graft	15.97	20.03			4
35585	Vein bypass graft	19.05	25.92			4
35656	Artery bypass graft	13.86	17.84			4

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
35654	Artery bypass graft	17.62	17.62	The ASGS recommended an increase from 17.62 to 23.05 RVUs.	No survey was conducted of vascular surgeons' work for this service, and the RUC did not feel sufficient rationale or evidence was provided to support a change from the current RVUs.	2
35681	Artery bypass graft	8.05	3.93	The ACS recommended reducing the RVUs for 35681 and 35875 based on a survey of general and vascular surgeons. Code 35681 is listed separately in addition to the code for the primary procedure, which could be any of the bypass graft procedures. It involved making a composite graft of a donor vein and segment of synthetic material to create enough length to accomplish the primary procedure, and would be used only if the obvious vein segment was not long enough. Code 35875 is equivalent to code 47556 for biliary endoscopy, with dilation of the stricture of the common bile duct.	The RUC agreed with the recommended reductions.	3
35875	Removal of clot in graft	9.07	8.19			3

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
Other Cardiovascular Procedures						
36215	Place catheter in artery	4.47	4.68	Comments from the SCVIR compared the work of code 36215 for [<i>Selective catheter placement arterial system; each first order thoracic or bracheocephalic branch within a vascular family</i>] to code 36245, which is for the same service but involves catheterization below the diaphragm. The comment states that previous RBRVS studies have demonstrated that the work involved in these services is equivalent whether the service is above or below the diaphragm, and an increase is recommended to make them equal.	The RUC agreed that codes 36215 and 36245 should have the same RVUs. No evidence was presented, however, that 36215 should be increased to equal the current RVUs for code 36245. The RUC recommends, therefore, that the RVUs for 36215 and 36245 be assigned a value equal to the frequency-weighted average of both codes. AMA data on Medicare claims indicate that 115,850 claims were submitted for code 36215 in 1994 and 63,952 claims were submitted for 35245, producing a new work-neutral value of 4.68 for both codes.	4
36245	Place catheter in artery	5.07	4.68			5 add
36218	Place catheter in artery	1.01 XXX	1.01 ZZZ	SCVIR comments identified codes 36218 and 36248 as undervalued because placement of a catheter in an additional second, third, or fourth order branch is frequently the most time and labor intensive aspect of selective and superselective arterial catheterization.	The RUC did not accept the SCVIR recommendation to increase the RVUs for codes 36218 and 36248 because no current survey data were presented. Since the codes for second and third order catheter placement can <i>never</i> be reported without also listing one of the codes for first order placement, however, the RUC recommends that the global periods for 36218 and 36248 be changed from XXX to ZZZ. Currently, the RVUs for these two services are reduced by 50% because they are reported as being done in addition to the first order placement. Since the codes are add-on codes, the RUC believes it would be more appropriate to assign a global period of ZZZ so that the RVUs are not halved every time the procedures are done.	4
36248	Place catheter in artery	1.01 XXX	1.01 ZZZ			4

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
36489	Insertion of catheter, vein	1.22	1.22	The ATS commented that the RVUs for code 36489 should be increased to be equal to code 36010 for <i>[Introduction of catheter, superior or inferior vena cava, 2.43 RVUs]</i> .	The ATS did not provide sufficiently compelling evidence to support the proposed increase. In addition, as explained by the SCVIR, the RVU difference between 36010 and 36489 appears justified. The RUC recommends that the current RVUs for 36489 be maintained.	2
36520	Plasma and/or cell exchange	1.74	1.74	The ASH recommended that the RVUs for 36520 be increased above the RVUs for code 90937 for hemodialysis, repeated evaluation.	The RUC did not believe sufficient evidence was provided by the ASH to support an increase in the RVUs from 1.74 to 2.60 for therapeutic apheresis. HCFA had recently reviewed the RVUs for this service and changed the global payment policy to consider certain evaluation and management services as being bundled with the procedure. In addition, claims data indicated that only 12% of the services are provided by hematologists. Larger percentages are provided by nephrologists, pathologists, and internists, but these specialties were not surveyed about the work involved in the service. The RUC recommends maintaining the current RVUs.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
36533	Insertion of access port	3.82	5.00	The ACS commented that a survey of general and vascular surgeons found that code 36533 for insertion of implantable venous access port is undervalued and code 36534 is overvalued.	The RUC's recommendation for these codes is based on a survey conducted by the ACS. An increase in 36533 from 3.82 to 5.00 will more appropriately value this service relative to other catheter procedures and venous codes, such as 62350 [<i>Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable infusion pump; without laminectomy, 6.25 RVUs</i>] and 63685 [<i>Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling, 6.29 RVUs</i>], which were recently reviewed by the RUC because of coding changes for <u>CPT 1996</u> . The recommended increase in 36533 is partially offset by a recommended decrease in 36534 from 3.79 to 2.73 RVUs, which achieves a better relationship within this family of codes. The RUC also compared the recommended RVUs to services on the MPC, including 32020 [<i>Insertion of chest tube, 3.98 RVUs</i>] and 32601 [<i>Diagnostic thoracoscopy, 5.46 RVUs</i>].	1
36534	Revision of access port	3.79	2.73			3
36620	Insertion catheter, artery	1.15	1.15	The ATS commented that the RVUs for code 36620 should be increased to be equal to code 36140 [<i>Introduction of needle or intracatheter; extremity artery, 2.01 RVUs</i>].	The ATS did not provide sufficiently compelling evidence to support the change. In addition, as explained by the SCVIR, the difference in RVUs between codes 36620 and 36140 appears justified. The RUC recommends that the current RVUs for 36140 be maintained.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
36830	Artery-vein graft	7.78	11.25	The ACS, SVS, and ASGS commented that code 36830 was undervalued based on a survey of general and vascular surgeons.	The RUC's recommendation for code 36830 is based on a survey of general, vascular, and transplant surgeons about the work involved in this service. The new value of 11.25 RVUs seems particularly reasonable in comparison to code 36821 for A-V fistula with vein, eg, Cimino type (8.39 RVUs), since 36830 involves two vascular anastomoses rather than one, insertion and tunneling of a prosthetic graft, and usually two incisions rather than one, but the current RVUs for 36830 are lower than 36821. The increased value also appeared reasonable in comparison to code 35661 [<i>Bypass graft, with other than vein, femoral-femoral</i> , 11.81 RVUs], 43420 [<i>Closure of esophagostomy or fistula; cervical approach</i> , 10.19 RVUs], and 43331, [<i>Esophagomyotomy (Heller type); thoracic approach</i> , 14.73 RVUs].	1
37730	Removal of leg veins	6.63	6.63	The ASGS commented that the RVUs for code 37730 should be increased to 8.60.	The ASGS did not provide additional evidence besides its comment. The RUC did not believe that sufficient data or rationale was presented to support this increase and recommends the current RVUs be maintained.	2
39400	Visualization of chest	5.11	5.11	The ASGS commented that the RVUs for code 39400 for mediastinoscopy should be increased to 7.97.	Claims data indicate that 56% of mediastinoscopy services are provided by thoracic surgeons. Since the ASGS had surveyed general but not thoracic surgeons, the RUC did not find the comment compelling and recommends the current RVUs be maintained.	2

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**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Speech/Language/Hearing

The American Speech-Language-Hearing Association (ASHA) and the American Academy of Audiology (AAA) submitted public comments on the following list of codes. In general these the comments expressed concern regarding HCFA's payment policies for audiologists and speech pathologists. These organizations are concerned that the current practice expense component does not accurately reflect the technical work that is involved in performing the services. In addition, the AAA comment noted that the current Medicare RBRVS includes zero work RVUs for audiology services, even though the Harvard study included physician work values for these codes. AAA notes that audiologists are currently authorized to seek direct reimbursement from HCFA and argues that work components should be developed to capture the interpretation and report.

ASHA and the American Academy of Otolaryngology-Head and Neck Surgery had originally responded to survey these services, however, they have now requested that the codes be withdrawn from further consideration. A majority of these codes have been revised for CPT 1996 and the RUC submitted recommendations to HCFA in May 1995.

The CMDs commented that 92512 *Nasal function studies (eg, rhinomanometry)* is similar to 94060 *Bronchospasm evaluation; spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise (rvu = .31)*. The RUC noted that Nasal function studies are performed to evaluate the normal or abnormal function of the nose. Rhinomanometry is a nasal function study that measures the flow and pressure of air through the nose. It enables the physician to assess the degree of obstruction, if any that may be present in the nasal passages. Anterior rhinomanometry, measures air flow in the front of the nasal cavity and is performed by inserting flexible air tubes into each nostril of the nose. The tubes are connected to a device that measures the amount and pressure of air that flows through them as the patient breathes. Measurements of air flow are recorded, and from this the physician calculates the degree of obstruction. Evaluation of wheezing (94060) is a distinctly different test which uses spirometry to measure exhaled gas and record the time of collection. 94060 is less intense than 92512 and requires less physician time than 92512. The RUC disagrees with this comment and recommends that the current value be maintained.

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Code	Descriptor	1995 RVU	RUC REC RVU	KEY
92506	Speech & hearing evaluation	0.86	0.86	2
92507	Speech/hearing therapy	0.52	0.52	2
92508	Speech/hearing therapy	0.26	0.26	2
92512	Nasal function studies	0.55	0.55	2
92541	Spontaneous nystagmus test	0.40	0.40	2
92542	Positional nystagmus test	0.33	0.33	2
92543	Caloric vestibular test	0.38	0.38	2
92544	Optokinetic nystagmus test	0.26	0.26	2
92545	Oscillating tracking test	0.23	0.23	2
92546	Torsion swing recording	0.29	0.29	2
92585	Brainstem evoked audiometry	0.50	0.50	2

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**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Cardiothoracic and Vascular Surgery

Comments were submitted by the American Society of General Surgeons (ASGS) and the Society of Thoracic Surgeons (STS) stating that lung procedures were not appropriately valued in the Harvard RBRVS study. In particular, comments noted that pre- and postservice times had been estimated by Harvard rather than directly measured and that the current RVUs do not reflect the physician work involved in: (1) maintaining proper hemodynamics during initiation of anesthesia, (2) stabilizing the patient for transfer to the recovery room, and (3) accumulating sufficient evidence that immediate reoperation or other intervention for bleeding, impaired circulation, or air leak is not needed. The STS also commented on several cardiac operations which it believes have become more complex over time, and recommended slight increases in 11 CABG procedures. The RUC did not believe that sufficiently compelling evidence was provided to support increases in the RVUs for thoracic procedures because most of these services have already been reviewed by the RUC, and any changes in work since the Harvard study should have been reflected in the RUC's 1993 recommendations. The RUC agreed that increases were warranted in two of the cardiac surgery procedures, mitral valve repair with prosthetic ring (33426) and descending thoracic aorta graft (33875), which have become more complex over the last five years.

The comments submitted by the International Society for Cardiovascular Surgery/The Society for Vascular Surgery (SVS) described a number of problems in the current RBRVS for vascular surgery procedures, many of which are due to the lack of any distinct study of vascular surgical procedures or vascular surgeons in the Harvard RBRVS study. This omission could have particularly deleterious effects for the Medicare program because Medicare patients account for an exceptionally high percentage of total patients seen by vascular surgeons. The comment notes, for example, that no vascular surgeons were included in the Harvard Technical Consulting Groups. It also describes errors in the Harvard vignettes, which could have resulted from the absence of vascular surgeons on the Harvard TCGs and led to incorrect data. The comment also notes that some adjustments were made in these services for the 1993 RBRVS based on an Abt study, but that further refinements are needed. Finally, the comments report the results of an effort to obtain intraoperative times from 10 hospitals for nine vascular procedures and eleven other codes selected from the Multispecialty Points of Comparison (MPC). This study found that, while data on nonvascular codes corresponded closely to existing Harvard and RUC data for the services, for vascular surgical codes the current data were 20% lower than the hospital reported times. The ASGS also commented on two vascular surgical procedures, code 34201 for femoropopliteal embolectomy or thrombectomy and code 35654 for axillary-femoral-femoral bypass graft, with other than vein.

The RUC found that the arguments presents by the SVS presented a compelling reason to review the current RVUs for selected vascular surgery procedures. It did not adopt the particular approaches or proposed RVUs recommended by the SVS, however. The alternative methods used to calculate the RUC-recommended RVUs are described below.

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Comments were received from the Society of Cardiovascular and Interventional Radiology (SCVIR), the American College of Surgeons (ACS), the American Society of Hematology (ASH), the American Thoracic Society (ATS), and the SVS and ASGS regarding nine other cardiovascular procedures. The RUC agreed with the SCVIR that there are anomalies in the current RVUs for codes 36215, 36218, 36245, and 36248. It is recommending a work neutral adjustment in the current RVUs for 36215 and 36245 to make them equal and is recommending a global period change for codes 36218 and 36248. The RUC adopted the increase recommended by the general and vascular surgeons for code 36830 for creation of arteriovenous fistula. For the remainder of the codes in this group, the RUC did not believe sufficient evidence was presented to support an increase and is recommending that the current RVUs be maintained.

Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
Thoracic Surgery						
32000	Drainage of chest	1.54	1.54	The Mayo Foundation commented that the work involved in thoracentesis is equivalent to tube thoracostomy (code 32020) because the intraservice times are equivalent.	None of the specialties on the RUC Advisory Committee elected to develop evidence supporting this contention, but data from the Harvard RBRVS study suggests tube thoracostomy requires more postservice work and time than thoracentesis. The RUC recommends maintaining the current RVUs.	2
32020	Insertion of chest tube	3.98	3.98	ASGS commented that the RVUs for tube thoracostomy should be increased from 3.98 to 4.94.	An Abt study for the ACS suggests the current RVUs are appropriate. The ASGS elected not to develop additional supporting evidence and the RUC recommends maintaining the current RVUs.	2
32100	Exploration/biopsy of chest	10.07	10.07	The STS and ASGS presented data on intraservice times for large numbers of patients who underwent thoracotomy (32100), pneumonectomy (32440), lobectomy (32480), and pulmonary wedge resection (32500), which suggested that the intraservice time assumptions underlying the current RVUs are too low.	A survey confirmed the STS comments that the intraservice times may be longer than the Harvard data suggest and that the recommended increases would make the services more appropriate in comparison to other codes in the family. The RUC recommends that the current RVUs be maintained, however, because they are based on recommendations made by the RUC and adopted by HCFA in 1993. Although the specialties provided ample evidence about the complexity of the services, they did not provide a compelling argument that the work had increased in the past two years.	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
32440	Removal of lung	19.15	19.15			2
32480	Partial removal of lung	16.84	16.84			2
32500	Partial removal of lung	13.10	13.10			2
32602	Thoracoscopy, diagnostic	5.96	5.96	The ASGS recommended that the RVUs for diagnostic thoracoscopy be increased from 5.96 to 11.81.	The current RVUs are based on a RUC recommendation. The RUC did not wish to revisit its previous recommendation and the ASGS elected not to develop and present additional evidence to support this comment. The RUC recommends maintaining the current RVUs.	2
Cardiac Surgery						
33010	Drainage of heart sac	2.24	2.24	Comments were submitted by an individual recommending that the RVUs be increased from 2.24 to 6.00.	None of the specialties on the RUC Advisory Committee elected to develop further evidence supporting this comment, and the RUC did not find the argument a convincing one.	2
33208	Insertion of heart pacemaker	7.28	7.28	The ASGS recommended the RVUs for pacemaker insertion or replacement be increased from 7.28 to 8.76.	The CPT codes for pacemaker services were recently reviewed by the RUC and neither the ASGS nor any of the other specialty societies pursued development of additional support for a change in the current RVUs.	2
33244	Remove generator	8.34	8.34	The American College of Cardiology recommended that the RVUs for 33244 be increased to 12.00.	The current RVUs for 33244 are based on recent recommendations from the RUC. No compelling evidence was presented to support another review of this code.	2
33425	Repair of mitral valve	25.57	25.57	The STS recommended an increase in the RVUs for mitral valve repair (33425) from 25.57 to 29.42, for mitral valve repair with prosthetic ring (33426) from 26.07 to	After in-depth study, the STS concluded that the current RVUs for codes 33425 and 33427 should be maintained and the RUC agreed. The RUC recommends that the RVUs for 33426 be increased to equal the RVUs for	2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
				29.42, and for mitral valve repair involving radical reconstruction with or without ring (33427) from 32.07 to 35.00. The STS described the work involved in codes 33245 and 33246 as being equivalent to mitral valve replacement (code 33430, 29.42 RVUs).	33430. Patients are more complex because those with mitral valve prolapse advancing to mitral regurgitation are surviving to an older age with medical management, with nearly half of Medicare patients aged 75 or older. Many of these patients have more advanced mitral regurgitation and present greater surgical challenges. The procedure is also being used for patients with mitral insufficiency. Also, whereas surgeons previously may have replaced the mitral valve with a prosthetic valve, they now attempt to reconstruct more valves because this is a safer option for patients. Such reconstruction may require insertion of a prosthetic ring in the dilated annulus, which is almost as much work as suturing in a prosthetic valve. A survey found that the code should actually be valued slightly higher than 33430, but the RUC did not find the survey data as compelling as the argument that the two codes should have equal work values.	
33426	Repair of mitral valve	26.07	29.42			4
33427	Repair of mitral valve	32.07	32.07			2
33510	CABG, vein, single	23.29	23.29	The STS commented that, in the process of developing the practice expense RVUs for these codes when they were revised in 1993, HCFA made adjustments in the work RVUs which sharply reduced the RUC-recommended differential between the arterial and venous codes to 0.72 rather than 2.18. The comment requested a technical correction.	HCFA can determine if a "technical correction" is warranted. As the comment notes, the CPT codes for CABG procedures were changed in 1993 and the RUC reviewed the RVUs for these services at that time. For 8 of the 10 codes, the requested increase is less than 10% of the current RVUs, and the RUC does not believe the survey process is sufficiently precise to validate such small changes through a new survey of work, so if the issue involves more than a technical correction, the RUC recommends the current RVUs be maintained.	2
33511	CABG, vein, two	25.57	25.57			2

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
33512	CABG, vein, three	27.84	27.84			2
33513	CABG, vein, four	30.12	30.12			2
33514	CABG, vein, five	32.39	32.39			2
33516	CABG, vein, six+	34.66	34.66			2
33533	CABG, arterial, single	24.00	24.00			2
33534	CABG, arterial, two	26.99	26.99			2
33535	CABG, arterial, three	26.98	26.98			2
33536	CABG, arterial, four+	32.96	32.96			2
33530	Coronary artery, bypass/reop	5.86	5.86	Comments stated the RVUs for CABG reoperation should reflect the higher likelihood of major intra- and postoperative complications compared to a primary CABG operation. The transverse aortic arch graft was described as the most challenging cardiovascular procedure performed today, and an increase to 49.91 RVUs was recommended.	The STS stated it was withdrawing codes 33530 and 33870 as it was unable to gather sufficient evidence to support the change. The RUC recommends that the current RVUs be maintained.	2
33870	Transverse aortic arch graft	37.74	37.74			2
33875	Thoracic aorta graft	26.94	31.23	Comments stated the work involved in descending thoracic aorta graft has increased over time as the procedure is now performed almost invariably with bypass, although the code descriptor states "with or without bypass." An increase was recommended from 26.94	A survey confirmed that the work of this service is equal to ascending aorta graft. Patients must be managed under both hypothermia and cardiopulmonary bypass, and the procedure entails risks of further aortic dissection and heavy bleeding. The RUC also noted that a high proportion of patients are African-Americans who are likely to have high blood pressure, renal	1

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
				to 31.23 RVUs to make it equivalent to ascending aorta graft, a code which is also performed invariably with bypass.	disease, and other conditions which add to the procedure's complexity. Use of bypass is now the standard of care, which adds the time to put the patient on bypass and converts the service from a closed to an open heart procedure. In comparing 33875 to 33860, the greatest work difference is in the dissection, particularly since 33875 can cause paralysis in the patient, which is not a risk in 33860. The RUC recommends 33875 be increased as recommended.	
Vascular Surgery						
34201	Removal of artery clot	8.04	8.04	The ASGS recommended an increase from 8.04 to 12.59 RVUs.	No survey was conducted of vascular surgeons' work for this service, and the RUC did not feel sufficient rationale or evidence was provided to support a change from the current RVUs.	2
35081	Repair defect of artery	22.15	26.23	As noted above, SVS comments described problems in the current RBRVS for vascular surgery procedures, mainly due to the lack of any distinct study of vascular surgical procedures or vascular surgeons in the Harvard RBRVS study. Intraoperative times were obtained from 10 hospitals for nine vascular procedures.	<p>The RUC found that the SVS comments constituted a compelling reason to review and revalue the codes addressed in their comments. They did not agree, however, with the specific approaches used by the SVS to develop new proposed values.</p> <p>The RUC recommends an increase to 26.23 RVUs for 35081 based on the evidence gathered by the SVS, which showed that the 167 minutes of intraservice time from the Harvard study was 35 minutes too short, the preoperative time was 40 minutes too short, and the IWPOT of 0.074 was too low:</p> <p>•The sum of (1) the additional Intraoperative time of 35 minutes at 0.08 per minute and (2) increasing the 167 minutes from the Harvard study from .074 to .08 per minute added 3.80 additional RVUs for intraservice work.</p>	4

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
					<ul style="list-style-type: none"> •The 40 additional minutes of preservice time at 0.028 units per minute added 1.00 RVUs for preservice work. •Adding 3.80 and 1.00 to the Harvard RVUs of 21.31 produced the recommended RVUs of 26.23, which is lower than the 28.50 RVUs recommended by the SVS. 	
35082	Repair artery rupture, aorta	28.82	34.20		The RUC recommends an increase to 34.20 RVUs, which would maintain the current relationship between codes 35081 and 35082 (35082 is 30% higher than 35081), and which is lower than the 37.00 RVUs recommended by the SVS.	4
35091	Repair defect of artery	28.10	33.16	See summary of SVS comment on previous page.	The RUC recommends an increase to 33.16 RVUs, which would maintain the current relationship between codes 35081 and 35091, and which is lower than the 36.50 RVUs recommended by the SVS.	4
35102	Repair defect of artery	23.44	28.80		The RUC considered the relationship between the SVS survey medians for codes 35081 and 35102 to be more appropriate than the ratio of the current RVUs for the codes. The SVS survey median for code 35102 was 30.74, and for code 35081 was 28.00. To calculate the recommended RVUs of 28.80 for 35102, the recommended RVUs of 26.23 for 35081 were multiplied by the ratio of the two survey medians. The SVS had originally recommended 31.50 RVUs for this service.	4
35301	Rechannelling of artery	15.95	17.79		The RUC recommendation for 35301 is based on data gathered by the SVS that it involves 143 minutes of intraoperative work rather than the two hours identified by the Harvard study. Valuing the additional 23 minutes at 0.08 IWP/PUT produced a new value of 17.79 RVUs.	4

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
35556	Artery bypass graft	15.47	19.37	See summary of SVS comments on p. 7.	<p>The RUC recommendations for these codes recognize the additional work involved in 35556 that is not recognized in the current RVUs, correct a rank order anomaly that currently exists between codes 35566 and 35585, and establish correct relationships between bypasses with vein and bypasses with in-situ vein. The SVS survey demonstrated that the current RVUs significantly underestimate the work involved in 35556. With a slight reduction to preserve a previous adjustment for work neutrality that was made in this family of codes, the increment of work between codes 35566 (<i>Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels</i>) and 35666 (<i>Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery</i>) was added to the current RVUs of 15.47 for code 35556 (<i>Bypass graft, with vein; femoral-popliteal</i>). The recommended RVUs for code 35583 (<i>In-situ vein bypass; femoral-popliteal</i>) are 3% higher than 35556, as they are currently. The current relationship between the femoral-popliteal and femoral-anterior tibial services is preserved in recommended increase for code 35566 from 20.21 to 24.45 RVUs. The recommended RVUs for code 35585 (<i>In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery</i>) are 6% higher than code 35566, rather than 6% lower as they are now. The current relationship between codes 35556 and 35656 (<i>Bypass graft, with other than vein; femoral-popliteal</i>) is also preserved in the recommended RVUs. The RUC-recommended values for these services are all lower than those proposed by the SVS.</p> <p>The newer, in-situ procedures involve somewhat more work than the older procedures because, instead of the vein being removed from its location and reversed, the incision is made along the entire length of the vein, the branches are tied off, and the two ends are freed up and sewn to the nearby artery. Since the veins have not been reversed, this leaves the problem of the one-way valves, which must then be mechanically disrupted to allow blood to flow through the conduit. Any false move with the valvulome can rip a huge hole in the vein, but publications suggest improved long-term graft patency when this in-situ technique is used.</p>	4
35566	Artery bypass graft	20.21	24.45			4
35583	Vein bypass graft	15.97	20.03			4

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Code	Descriptor	95 RVU	RUC REC RVU	Comment	RUC Rationale	Key
35585	Vein bypass graft	19.05	25.92			4
35656	Artery bypass graft	13.86	17.84			4
35654	Artery bypass graft	17.62	17.62	The ASGS recommended an increase from 17.62 to 23.05 RVUs.	No survey was conducted of vascular surgeons' work for this service, and the RUC did not feel sufficient rationale or evidence was provided to support a change from the current RVUs.	2
35681	Artery bypass graft	8.05	3.93	The ACS recommended reducing the RVUs for 35681 and 35875 based on a survey of general and vascular surgeons. Code 35681 is listed separately in addition to the code for the primary procedure, which could be any of the bypass graft procedures. It involved making a composite graft of a donor vein and segment of synthetic material to create enough length to accomplish the primary procedure, and would be used only if the obvious vein segment was not long enough. Code 35875 is equivalent to code 47556 for biliary endoscopy, with dilation of the stricture of the common bile duct.	The RUC agreed with the recommended reductions.	3
35875	Removal of clot in graft	9.07	8.19			3

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Other Cardiovascular Procedures						
36215	Place catheter in artery	4.47	4.68	Comments from the SCVIR compared the work of code 36215 for <i>Selective catheter placement arterial system; each first order thoracic or brachiocephalic branch within a vascular family</i> to code 36245, which is for the same service but involves catheterization below the diaphragm. The comment states that previous RBRVS studies have demonstrated that the work involved in these services is equivalent whether the service is above or below the diaphragm, and an increase is recommended to make them equal.	The RUC agreed that codes 36215 and 36245 should have the same RVUs. No evidence was presented, however, that 36215 should be increased to equal the current RVUs for code 36245. The RUC recommends, therefore, that the RVUs for 36215 and 36245 be assigned a value equal to the frequency-weighted average of both codes. AMA data on Medicare claims indicate that 115,850 claims were submitted for code 36215 in 1994 and 63,952 claims were submitted for 35245, producing a new work-neutral value of 4.68 for both codes.	4
36245	Place catheter in artery	5.07	4.68			5 add
36218	Place catheter in artery	1.01 XXX	1.01 ZZZ	SCVIR comments identified codes 36218 and 36248 as undervalued because placement of a catheter in an additional second, third, or fourth order branch is frequently the most time and labor intensive aspect of selective and superselective arterial catheterization.	The RUC did not accept the SCVIR recommendation to increase the RVUs for codes 36218 and 36248 because no current survey data were presented. Since the codes for second and third order catheter placement can <i>never</i> be reported without also listing one of the codes for first order placement, however, the RUC recommends that the global periods for 36218 and 36248 be changed from XXX to ZZZ. Currently, the RVUs for these two services are reduced by 50% because they are reported as being done in addition to the first order placement. Since the codes are add-on codes, the RUC believes it would be more appropriate to assign a global period of ZZZ so that the RVUs are not halved every time the procedures are done.	4
36248	Place catheter in artery	1.01 XXX	1.01 ZZZ			4
36489	Insertion of catheter,	1.22	1.22	The ATS commented that the RVUs for	The ATS did not provide sufficiently compelling	2

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	vein			code 36489 should be increased to be equal to code 36010 for <i>Introduction of catheter, superior or inferior vena cava, 2.43 RVUs</i> .	evidence to support the proposed increase. In addition, as explained by the SCVIR, the RVU difference between 36010 and 36489 appears justified. The RUC recommends that the current RVUs for 36489 be maintained.	
36520	Plasma and/or cell exchange	1.74	1.74	The ASH recommended that the RVUs for 36520 be increased above the RVUs for code 90937 for hemodialysis, repeated evaluation.	The RUC did not believe sufficient evidence was provided by the ASH to support an increase in the RVUs from 1.74 to 2.60 for therapeutic apheresis. HCFA had recently reviewed the RVUs for this service and changed the global payment policy to consider certain evaluation and management services as being bundled with the procedure. In addition, claims data indicated that only 12% of the services are provided by hematologists. Larger percentages are provided by nephrologists, pathologists, and internists, but these specialties were not surveyed about the work involved in the service. The RUC recommends maintaining the current RVUs.	2
36533	Insertion of access port	3.82	5.00	The ACS commented that a survey of general and vascular surgeons found that code 36533 for insertion of implantable venous access port is undervalued and code 36534 is overvalued.	The RUC's recommendation for these codes is based on a survey conducted by the ACS. An increase in 36533 from 3.82 to 5.00 will more appropriately value this service relative to other catheter procedures and venous codes, such as 62350 (<i>Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable infusion pump; without laminectomy, 6.25 RVUs</i>) and 63685 (<i>Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling 6.29 RVUs</i>), which were recently reviewed by the RUC because of coding changes for CPT 1996. The recommended increase in 36533 is partially offset by a recommended decrease in 36534 from 3.79 to 2.73 RVUs, which achieves a better relationship within this family of codes. The RUC also compared the recommended RVUs to services on the MPC, including 32020 (<i>Insertion of chest tube, 3.98 RVUs</i>) and 32601	1

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					<i>Diagnostic thoracoscopy</i> , 5.46 RVUs.	
36534	Revision of access port	3.79	2.73			3
36620	Insertion catheter, artery	1.15	1.15	The ATS commented that the RVUs for code 36620 should be increased to be equal to code 36140 (<i>Introduction of needle or intracatheter; extremity artery</i> , 2.01 RVUs).	The ATS did not provide sufficiently compelling evidence to support the change. In addition, as explained by the SCVIR, the difference in RVUs between codes 36620 and 36140 appears justified. The RUC recommends that the current RVUs for 36140 be maintained.	2
36830	Artery-vein graft	7.78	11.25	The ACS, SVS, and ASGS commented that code 36830 was undervalued based on a survey of general and vascular surgeons.	The RUC's recommendation for code 36830 is based on a survey of general, vascular, and transplant surgeons about the work involved in this service. The new value of 11.25 RVUs seems particularly reasonable in comparison to code 36821 for A-V fistula with vein, eg, Cimino type (8.39 RVUs), since 36830 involves two vascular anastomoses rather than one, insertion and tunneling of a prosthetic graft, and usually two incisions rather than one, but the current RVUs for 36830 are lower than 36821. The increased value also appeared reasonable in comparison to code 35661 (<i>Bypass graft, with other than vein, femoral-femoral</i> , 11.81 RVUs), 43420 (<i>Closure of esophagostomy or fistula; cervical approach</i> , 10.19 RVUs), and 43331, (<i>Esophagomyotomy (Heller type); thoracic approach</i> , 14.73 RVUs).	1
37730	Removal of leg veins	6.63	6.63	The ASGS commented that the RVUs for code 37730 should be increased to 8.60.	The ASGS did not provide additional evidence besides its comment. The RUC did not believe that sufficient data or rationale was presented to support this increase and recommends the current RVUs be maintained.	2
39400	Visualization of chest	5.11	5.11	The ASGS commented that the RVUs for code 39400 for mediastinoscopy should be increased to 7.97.	Claims data indicate that 56% of mediastinoscopy services are provided by thoracic surgeons. Since the ASGS had surveyed general but not thoracic surgeons, the RUC did not find the comment compelling and	2

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

KEY: 1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality

					recommends the current RVUs be maintained.	
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CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

KEY: 1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 33426 Global Period: 090 Current RVW: 26.07 Recommended RVW: 30.00

CPT Descriptor: Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring

Source and Summary of Comment to HCFA on this service: STS was the source of this comment. STS disagrees with the methodology that resulted in compressed and lowered values for this service in the original Hsaio study. Abt Associates did a follow-up study that directly measured both work and time and demonstrated greater amounts of work and time for this surgical procedure, especially in the pre- and postoperative period of complex operations. In addition, the rise in average age and severity of illness of these patients since the Hsaio study has increased the work and intensity factors of this procedure.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old woman with known heart murmur of mitral insufficiency of at least 20 yrs duration suddenly developed symptoms of heart failure. History and physical and transesophageal echocardiogram demonstrated a flail posterior leaflet of the mitral valve with severe mitral regurgitation, and normal ventricular contractility. Her symptoms proved refractory to medical therapy. The patient was admitted to the hospital prior to the scheduled operation and was reevaluated by the surgeon who again reviews her medical record, echocardiographic findings, and both laboratory and EKG results. Informed consent is obtained. The planned procedure was discussed with the anesthesiologist. At the time of operation via median sternotomy, the patient was placed on cardiopulmonary bypass, after which the left atrium was exposed posterior to the intraatrial groove after adequate mobilization. Inspection of the mitral valve revealed myxomatous changes of both the anterior and posterior leaflet. The middle portion of the posterior leaflet was flailed. A quadrangular incision of the flailed portion of the posterior leaflet was excised, and the leaflet was repaired with interrupted sutures of 5-0 Prolene. Because the annulus was dilated, an annuloplasty ring was inserted with multiple, interrupted Prolene sutures. After completion of cardiopulmonary bypass, transesophageal echocardiogram confirmed valvular competence. The patient was sent to the ICU and stabilized. Following a routine postop course, she was started on heparin anticoagulation and ultimately Coumadin. She was discharged after 8 days in hospital. Postoperative visits were for suture removal, routine postop checkups and Coumadin regulation.

Description of Pre-Service Work: The patient is admitted to the hospital the morning of the scheduled operation and is re-evaluated by the surgeon who again reviews the patient's medical record, echocardiograms, EKGs, and laboratory results. The risks and likely outcomes of the procedure are re-discussed with the patient. Informed consent is verified or obtained if not previously done. The planned procedure is discussed with the anesthesiologist. The surgeon then changes into surgical clothes and waits for the patient to be brought into the operating room. After the patient is anesthetized, the surgeon places the patient in the appropriate position on the operating room table. The surgeon then scrubs his or her hands and arms before gowning for the surgical procedure.

Description of Intra-Service Work: At the time of operation via median sternotomy, the patient is placed on cardiopulmonary bypass and cardioplegia is instituted, after which the left atrium is exposed posterior to the intraatrial groove after adequate mobilization. Inspection of the mitral valvular leaflets and subvalvular structures will determine the approach. For example, with myxomatous changes of both the anterior and posterior leaflet and the middle portion of the posterior leaflet flailed, the procedure would go as follows: A quadrangular incision of the flailed portion of the posterior leaflet is excised, and the leaflet is repaired with interrupted sutures of 5-0 Prolene. With the annulus dilated, an annuloplasty ring is inserted with multiple, interrupted Prolene sutures. After completion of cardiopulmonary bypass, transesophageal echocardiogram must confirm valvular competence.

Description of Post-Service Work: The patient is evaluated in the post-anesthesia recovery unit immediately upon arriving for bleeding and cardiac function. At least two postoperative transesophageal echocardiograms are reviewed. Fluid orders are written, pain control is initiated, and ventilatory parameters are adjusted if the patient remains intubated. When indicated, the patient is extubated and ICU orders are written. Within the next few hours the patient is transferred to an intensive care unit where the surgeon again evaluates the patient for bleeding and cardiopulmonary function. Valve status, hemodynamics, and cardiac rhythm are again tested and reviewed. Within the next 12 hours, two subsequent visits are made by the surgeon to evaluate similar parameters.

During the remainder of the hospitalization the patient is seen daily, during which time the patient is physically examined, transesophageal echocardiograms are reviewed, respiratory status and cardiac rhythm are observed, and general recovery is evaluated. The patient is started on a liquid diet the second postoperative day and advanced to a general diet on the third. Pain control is instituted with parenteral and oral medications. The chest tubes are removed one at a time over a two to three day period usually starting on the third or fourth postoperative day.

Following hospital dismissal, the patient is seen in an office setting within the next week and then monthly thereafter for 3 months, during which time the incision site, the chest, the anticoagulation regimen, and cardiac function are evaluated. Skin sutures are removed at the first office visit. Questions by both patient and family are answered.

SURVEY DATA:

Specialty: Society of Thoracic Surgeons

Sample Size: 50 Response Rate (%): 80% (40/50) Median RVW: 30.00

25th Percentile RVW: 29.00 75th Percentile RVW: 30.50 Low: 24.80 High: 32.00

Median Pre-Service Time: 60 min Median Intra-Service Time: 250 min

25th Percentile Intra-Svc Time: 210 min 75th Percentile Intra-Svc Time: 300 min Low: 180 min

High: 480 min

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>60 min</u>	
ICU:	<u>60 min</u>	<u>3</u>
Other Hospital:	<u>90 min</u>	<u>6</u>
Office:	<u>30 min</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	33422	Valvotomy, mitral valve; open heart with cardiopulmonary bypass	23.72
2)	33430	Replacement, mitral valve; with cardiopulmonary	29.42

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The code is closely related to the other two codes. CPT 33422 is a mitral valve repair, also, but of a simpler nature, somewhat less intense, and thus valued lower. CPT 33430 is also a mitral valve procedure, of nearly the same level of difficulty as the mitral valvuloplasty with the annuloplasty ring insertion. The mitral valve procedure family of codes would be in appropriate rank order with the upgrading of CPT 33426.

It is notable that the pre-service work with mitral valvuloplasty sometimes exceeds that done with mitral valve repair because of the need to educate the patient regarding anticoagulation following surgery and the possibility of mitral valve replacement in the future,

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Our survey data indicate that patients undergoing this procedure are more complex than they were five years ago. While mitral valve repairs are not necessarily done only in the elderly population, patients with mitral valve prolapse advancing to mitral regurgitation are surviving to an older age with medical management. Many of these patients have more advanced mitral regurgitation and present greater surgical challenges. Whereas, in the past we might have replaced their mitral valve with a prosthetic valve, now we are attempting to reconstruct more valves than we used to because it is a safer option for the patient. In many cases reconstruction necessitates the insertion of a prosthetic ring in the dilated annulus, which is almost as much work as suturing in a prosthetic valve. We believe, with the added preoperative work and the extra work of repair on a more diseased valve with the ring insertion, that this code deserves to be raised to 30.00 RVWs to be in appropriate rank order with the mitral valve surgery codes.

Public Comments

30-Jun-95

Code: 33426

1995 RVUs: 26.07

Recommended RVUs: 29.42

Ratio:

Long Descriptor: Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring

Reference Set (y/n): Y Global Period: 090 Frequency: 1,565 Impact: 5246

Source: 2 Year: 92 Public Comment Letter: 308

Reference Services:

CMD Comment:

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Societies Wishing to Survey: STS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
33426	47.2	0	2.8	52.8	2.8	2.8	2.8	8.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
33426	1216	1653	16.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
33426	99.1	99.9	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
33426	cardiac surgery	30.6
	cardiovascular disease	6
	general surgery	2.8
	group practices	5.1
	thoracic surgery	54.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
33426	394	2.1	DISEASES OF MITRAL VALVE
	396	2.1	DISEASES OF MITRAL AND AORTIC VAL

Public Comments

30-Jun-95

397	1.4	DISEASES OF OTHER ENDOCARDIAL STR
414	11.1	OTHER FORMS OF CHRONIC ISCHEMIC H
424	22.9	OTHER DISEASES OF ENDOCARDIUM
428	1.4	HEART FAILURE
429	2.1	ILL-DEFINED DESCRIPTIONS AND COMP

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
33426							
STS		090	090	24.07	26.07	1.08	26.07

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
33426								
STS	26.07	26.07	1.08	1.00	1.00	1.00	29.42	308

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
33426								
STS	090	24.07		46		203		87

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
33426									
STS		2.0		10	8.5		15	3.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
33426									
STS		20		29.42	26.07	ts	3		0.069

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 33875 Global Period: 090 Current RVW: 26.94 Recommended RVW: 31.23

CPT Descriptor: Descending thoracic aorta graft, with or without cardiopulmonary bypass

Source and Summary of Comment to HCFA on this service: STS was the source of this comment. STS disagrees with the methodology that resulted in compressed and lowered values for this service in the original Hsaio study. Abt Associates did a follow-up study that directly measured both work and time and demonstrated greater amounts of work and time for this surgical procedure, especially in the pre- and postoperative period of complex operations. In addition, the rise in average age and severity of illness of these patients since the Hsaio study has increased the work and intensity factors of this procedure.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year-old hypertensive man was admitted to the hospital because of back pain and an enlarged descending thoracic aorta detected on chest x-ray. CT scan confirmed a descending thoracic aortic aneurysm measuring 6.5 cm in diameter in the mid-chest. A moderate left pleural effusion was noted. The patient was seen by a cardiothoracic surgeon who reviewed the patient's CT scan and laboratory studies and did a physical examination. Urgent graft replacement of the descending thoracic aorta was proposed and discussed with the patient and family and informed consent obtained. After discussing the planned procedure with the anesthesiologist and bypass team, the patient's chest was entered through a left posterolateral incision, and the left common femoral artery and left atrium were cannulated. The patient underwent partial cardiopulmonary bypass and mild hypothermia. The thoracic aortic aneurysm was excluded by placing a vascular clamp between the left carotid and left subclavian arteries and distally above the diaphragm. The aneurysm was then opened, intercostal arteries suture-ligated proximally and prepared for reimplantation distally, and the thoracic aorta replaced with a Dacron graft. The distal graft-to-aorta anastomosis was performed about 8 cm above the diaphragm and the intercostals reimplanted. The left atrium and femoral artery were decannulated and repaired. The patient's chest incision was then closed after control of bleeding, and he was taken to the surgical intensive care unit where he was stabilized. He was extubated within 24 hours and transferred out of intensive care on the 2nd postoperative day. He was discharged on the 8th postoperative day. He was seen for office visits for routine postoperative care and evaluation of followup CT scans.

Description of Pre-Service Work: The patient is admitted to the hospital the morning of the scheduled operation and is re-evaluated by the surgeon who again reviews the patient's C-T scan, x-ray findings, and laboratory results. The patient is physically examined. Informed consent is verified or obtained if not previously done. The planned procedure is now discussed with the anesthesiologist. The surgeon then changes into surgical clothes and waits for the patient to be brought into the operating room. After the patient is anesthetized, the surgeon places the patient in the left lateral decubitus position on the operating room table. The surgeon then scrubs his or her hands and arms before gowning for the surgical procedure.

Description of Intra-Service Work: Typically, the patient's chest is entered through a left posterolateral incision, and the left common femoral artery and left atrium are cannulated. The patient is put under partial cardiopulmonary bypass and mild hypothermia. The thoracic aortic aneurysm is excluded by placing a vascular clamp between the left carotid and left subclavian arteries and distally above the diaphragm. The aneurysm is then opened. It may be necessary to tuck back the intima and adventitia together and eliminate the false lumen produced between the adventitia and intima using a double Teflon sandwich technique. The intercostal arteries are suture-ligated proximally and prepared for reimplantation distally, and the thoracic aorta is replaced with a Dacron graft. The distal graft-to-aorta anastomosis was performed about 8 cm above the diaphragm and the intercostals are reimplanted. The

left atrium and femoral artery are decannulated and repaired. Stopping of retrograde cerebral perfusion, reinstatement of cardiopulmonary bypass, rewarming and termination of cardioplegia and cardiopulmonary bypass are done in sequence. Venting of air emboli is done in the cardiac chambers and in the graft. The patient's induced coagulopathy is dealt with. The patient's chest incision is then closed after control of bleeding.

Description of Post-Service Work: The patient is evaluated in the postanesthesia recovery unit immediately upon arriving for bleeding, cardiac function, blood pressure stability. Postoperative chest x-rays EKGs, C-T scans, angiograms, blood gases, cardiac rhythm, and hemodynamic status are reviewed. Fluid orders are written, pain control is initiated, and ventilatory parameters are adjusted if the patient remains intubated. When indicated, the patient is extubated; within the next few hours the patient is transferred to an intensive care unit where the surgeon again evaluates the patient for bleeding; cardiac function, hemodynamic status and neurologic function. Within the next 12 hours, two subsequent visits are made by the surgeon to evaluate similar parameters.

During the remainder of the hospitalization the patient is seen daily, during which time the patient is physically examined. Further chest x-rays and C-T scans are reviewed, hemodynamic status and cardiac rhythm are observed. The patient is started on a liquid diet the second postoperative day and advanced to a general diet on the third. Pain control is instituted with parenteral and oral medications. The chest tubes are removed one at a time over a two to three day period usually starting on the third or fourth postoperative day.

Following hospital dismissal, the patient is seen in an office setting within the next week and then monthly thereafter for 3 months, during which time the incision site, chest, cardiac function, and hemodynamic status are evaluated. Skin sutures are removed at the first office visit. Questions by both patient and family are answered.

SURVEY DATA:

Specialty: Society of Thoracic Surgeons

Sample Size: 50 Response Rate (%): 84% (42/50) Median RVW: 31.23

25th Percentile RVW: 28.68 75th Percentile RVW: 33.00 Low: 24.00 High: 36.00

Median Pre-Service Time: 60 min Median Intra-Service Time: 300 min

25th Percentile Intra-Svc Time: 240 min 75th Percentile Intra-Svc Time: 360 min Low: 180 min

High: 500 min

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>60 min</u>	
ICU:	<u>60 min</u>	<u>4</u>
Other Hospital:	<u>90 min</u>	<u>6</u>
Office:	<u>40 min</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	33860	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension	31.23
2)	33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	32.26

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The code under review is quite similar in work effort, intensity, and fundamental nature to 33860. Both involved graft repairs of the aorta, using similar operative techniques. The fact that the survey came up with a suggested RVW for 33875 that is the same as the reference code further reinforces this. The effort involved in 33412, the other reference code is also quite similar. This aortic valve replacement with aortic annulus enlargement is slightly more difficult because of the need to enlarge the aortic annulus to replace the valve.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This is a difficult operative procedure where the patient must be managed under both hypothermia and cardiopulmonary bypass. Our survey indicates that patients have become older, sicker, and more complex in the past 10 years. There is great intensity involved in the procedure because of the danger of further aortic dissection and heavy bleeding. Survey results which valued this procedure so closely to the ascending arch repair testify to the fact that this procedure has been undervalued. In addition, when this code was first established, the descriptor indicated that it could be done with or without cardiopulmonary bypass. The technology and the patient mix have changed to the point where now this procedure is virtually always done on cardiopulmonary bypass, thus increasing the overall work involved.

Public Comments

30-Jun-95

Code: 33875

1995 RVUs: 26.94

Recommended RVUs: 31.23

Ratio:

Long Descriptor: Descending thoracic aorta graft, with or without bypass

Reference Set (y/n): N

Global Period: 090

Frequency: 750

Impact: 3218

Source: 1

Year: 92

Public Comment Letter: 308

Reference Services:

CMD Comment:

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Societies Wishing to Survey: STS

Societies Wishing to Comment: SVS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
33875	36.4	4.5	23.8	36.4	9.1	0	0	14.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
33875	797	881	5.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
33875	98.4	99.8	0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
33875	cardiac surgery	27.8
	cardiovascular disease	4.5
	general surgery	7.4
	group practices	5.4
	thoracic surgery	49.8
	vascular surgery	4.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
33875	280	1.1	IRON DEFICIENCY ANEMIAS

Public Comments

30-Jun-95

414	4.5	OTHER FORMS OF CHRONIC ISCHEMIC H
441	20.5	AORTIC ANEURYSM
512	1.1	PNEUMOTHORAX
569	1.1	OTHER DISORDERS OF INTESTINE
901	2.3	INJURY TO BLOOD VESSELS OF THORAX
998	1.1	OTHER COMPLICATIONS OF PROCEDUR

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
33875							
STS		090	090	28.39	26.94	0.95	26.94

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
33875								
STS	26.94	26.94	0.95	1.00	1.00	1.00	31.23	308

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
33875								
STS	090	28.39		32		228		75

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
33875									
STS		1.0		10	8.5		10	4.5	1.4

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
33875									
STS		20		31.23	26.94	ts	3		0.086

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 35081 **Global Period:** 090 **1995 RVW:** 22.15 **Recommended RVW:** 28.50

CPT Descriptor: Direct repair of aneurysm or excision (partial or total) and graft insertion for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 11 vascular surgeons designed a study to measure the major component of work for vascular surgical procedures. Accurate intraoperative (skin-to-skin) surgery times of commonly performed vascular and non-vascular procedures were collected from operative logs and computer databases at ten hospitals, both private and University. Median intra-service time and intra-service work per minute (IWPUT) were calculated (Table 1). The results of this study identified the intra-service work of code 35081 to be significantly undervalued based on a comparison with typical "signature" procedures from many other surgical disciplines. This comparison of intra-service work formed the basis for choosing 35081 to be surveyed for all aspects of work in the five year review.

1994 Frequency of Service: 16,818

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71 year old hypertensive asymptomatic 5'10" male weighing 95 kilograms with a history of a myocardial infarction and a 50 pack-year history of smoking has a 6.5 cm infrarenal abdominal aortic aneurysm by ultrasound. Extensive pre-op work-up is done. Appropriate invasive monitoring is done with insertion of a Swan-Ganz catheter, arterial line, Foley catheter, NG tube and sequential compression devices applied. Standard aortic aneurysmectomy with a tube graft is performed. The patient is in the ICU on a ventilator for 48 hours postoperatively and requires real-time hemodynamic monitoring, close monitoring of urinary output, diuretic support, and fluid management. The patient is transferred to the floor after 72 hours. The remainder of his postoperative course is uneventful and he is discharged to home on the 10th postoperative day.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before surgery until the time of the procedure. This work includes review of hospital admission workup with special attention to cardiopulmonary and hematologic status; review of CT scans, ultrasound studies, arteriograms, and laboratory tests; communication with referring physician, cardiologist, anesthesiologist and other health care professionals as necessary; review of indications, risks and benefits of surgery with patient and family; signature of informed consent; and preview of expected hospital course, pain management, discharge plans etc. with patient and family. Pre-service work also includes changing into OR scrubs, hand scrubbing, and waiting for surgery: supervision of positioning, skin preparation, and draping of the patient; and insuring that surgical instruments and necessary supplies are present and available in the operative suite. Surgical presence is also required as the anesthesiology team proceeds with lumbar epidural catheter placement and testing, insertion of a Swan-Ganz catheter, insertion of arterial pressure line, and induction of general endotracheal anesthesia.

Description of Intra-Service work: The abdomen is incised from the xiphoid to the pubis, the peritoneal cavity is opened, and general exploration is made for the presence of tumors, gall bladder abnormalities, adhesions, and correct positioning of the NG tube. The intestines are reflected to the right upper quadrant of the abdominal cavity. A self-retaining retractor system is connected to the operating table and appropriate blades are placed to achieve exposure of the aorta. The retroperitoneum and ligament of Treitz are incised, and the duodenum is reflected away from the aorta. The aneurysm is exposed proximally until normal aortic tissue is encountered at the level of the left renal vein. The renal vein is mobilized carefully, and the aorta at this level is mobilized sufficiently to prepare for its subsequent division. The upper portion of the aneurysm is inspected to insure that no unsuspected accessory renal arteries arise from its surface, and the inferior mesenteric artery, which arises from the body of the aneurysm, is identified and inspected for patency. The common iliac arteries are exposed to allow occlusion during aneurysm repair. Special attention is paid to avoid injury to the nearby ureters and iliac veins.

others, found in the vascular patient. The vignette patient, having had a previous myocardial infarction, is a true representative of the aortic aneurysm cohort. Preparation time in the OR is similar for 35081 and 47130. Both require full hemodynamic monitoring typically associated with operations which may induce physiologic instability. Thus, pre-service work of 107.5 minutes for 35081 is 28.5 minutes (36%) greater than 47130. The median survey intra-service time of 202.5 min. for 35081 is 29.5 min., or 12.7% less than the 232 min. intra-service time of 47130. Median post-service time on the day of surgery for 35081 of 60 min. is 20 min. more than the 40 min. same day post-service for 47130. Both codes have 4 ICU visits with a total of 60 min. (The Harvard / RUC summary suggests there are 4 x 10 minute visits for 47130, but the survey suggests 4 x 15 min visits. We used the higher value, giving any potential bias to the reference code) 35081 has 7 post-ICU hospital visits consuming 90 minutes while 47130 has 11 hospital visits requiring 110 minutes. 35081 has 2 x 20 minute post-discharge office visits while 47130 has 4.5 x 15 minute office visits. Overall, 35081 has 250 minutes of post-operative care in the global period compared to 278 minutes of post-service time for 47130. Thus, 35081 has 10% less post-service time than the comparison service.

Intensity Comparison to 47130: The mental effort and judgment, technical skill and physical effort, and psychological stress involved in 35081 is similar to that of 47130. Both procedures lie in the upper spectrum of surgical skill and effort for surgeons in general. For those whose practices are not focused on liver or aneurysm surgery, both procedures can be very taxing and fraught with challenges. For surgeons who specialize in hepatic or vascular surgery, these 2 procedures are considered challenging but not extraordinary. Both operations usually proceed without undue cardiovascular instability, but truly complex intraoperative situations, such as massive hemorrhage, does occur with with a low but real frequency.

Summary of comparison to 47130: 35081 has 36% more pre-service work, 12.7% less intra-service work, and 10% less post-service work than 47130. The 1995 work value for 47130 is 31.56 units. Sixty percent of the total work for this service is intra-service work, making the intraservice component 18.94 work units and the pre+post-service work 12.62 units. Pre-service work represents approximately 22% of the sum of pre and post service work for this service. Since 35081 has 36% more pre-service work and pre-service work is 22% of pre+post, then 35081 has 3.78 pre-service work units ($12.62 * 0.22 * 1.36$). Assuming 35081 has 12.7% less intra-service work, the relative intraservice work would be 16.53 units ($18.94 * 0.873$). Since 35081 has 10% less post-service work, the relative post-service work is 8.86 units ($12.62 * 0.78 * 0.90$). Thus, the total work for 35081 is the sum of 3.78 pre-service units, plus 16.53 intra-service units, plus 8.86 post-service units, or **29.17 units**.

Comparison to E/M Codes: The work of 35081 may be calculated as the sum of the following E/M services, using intensive care codes as the best comparison to the complex intra-service work involved in aortic aneurysm repair:

<u>Service</u>	<u>Time</u>	<u>E/M Code</u>	<u>RVW</u>
Pre-service	107.5	99215	1.51
Intra-service	202.5	99291 + 99292 x 5	12.84
Day of proc, post-op	60	99291	3.64
POD #1 ICU	30	99291	3.64
POD#2 ICU	15	99233	1.25
POD#3 ICU	15	99233	1.25
POD #4,5	15	99232 x 2	1.76
POD #6-9	10	99231 x 4	2.04
POD #10 Disch	20	99238	1.06
Office x2	40	99213	1.10
Total:			30.09

Thus, by using an E/M reference service building-block method the work of 35081 should be **30.09 units**.

RATIONALE:

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work; time; technical skill; and physical effort; mental effort; and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research

The recommended increase in RVW is based upon improvements in the accuracy of existing Harvard work, time, and intensity data for this code.

1. **Work:** The Harvard work value was originally estimated at 21.31 units by a panel without substantial participation by vascular surgeons. The RVW was increased by 4% in 1992 to 22.15 units, and no further adjustments have been made since then. The current survey suggests that the work value should be 28 units (median value), and even the 25th percentile survey RVW of 25 units is 13% greater than the current 1995 work value. The median survey value is justified by the detailed comparison to the key reference service which suggested a value of 29.17 units, and by the E/M building-block calculation of 30.09 units. In addition, the work survey reported by the American College of Surgeons in their February 6, 1995 Comment to HCFA (Appendix VIII in that report) suggests a work value of 29.49 for this service.
2. **Time:** Based on the survey data, the Harvard data underestimate all 3 time segments. The Harvard pre-service time for this procedure is 67.5 minutes, while the survey respondents' median pre-service time is 107.5. The Harvard intra-service time is 167 minutes, while the survey median intra-service time is 202.5 minutes. Our survey also requested that physicians report the actual times for their last three procedures. The mean value for those procedures was 192 minutes and the median was 185 minutes. As another measure of intra-service time, the survey requested respondents to supply actual time data for their hospitals, and the volume weighted mean of these institutions median time was 202 minutes. Finally, the SVS 10 hospital OR data analysis determined a median intra-service time of 230 minutes for a sample of 297 operations. These times are summarized in Table 2. Considered together, they suggest the best estimate of intra-service time for 35081 is 200-210 minutes, 30 to 40 minutes more than the current Harvard estimate. Finally, post-service time according to existing Harvard data is 203.5 minutes, while survey respondents' median time was 250 minutes.
3. **Intensity:** Intensity of most arterial reconstructive vascular procedures is quite high due to potential for intraoperative catastrophe such as major hemorrhage, and due to potential for major postoperative complications such as myocardial infarction. The intensity of 35081 was rated as having a median mental effort value of 4, median technical skill value of 4, and median psychological stress value of 4. While intensity is difficult to evaluate quantitatively, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. In contrast to the high intensity judged by the survey respondents, the IWPUT for 35081 in 1995 is 0.056 when calculated using the 1995 RVW and the accurate intra-service times from our SVS 10-hospital OR data analysis (Table 1). Likewise, RUC/Harvard IWPUT for this operation is only 0.074 according to the Summary of work and time estimates for services undergoing investigation (AMA RUC 6/8/95). This is less than that for TURP (0.120), cataract removal (0.110), total knee arthroplasty (0.084), and several other common services (Table 1). If 35081 is recalculated using the median IWPUT from the SVS study (0.082), a more accurate reflection of intra-service intensity is reached. By this technique, intra-work is $202.5 \times 0.082 = 16.61$ units. Since intra-work represents 0.54 of total work per the current survey, the total work is $16.61 / 0.54 = 30.76$ units (see Appendix for an expanded discussion). Thus, by adjusting the intensity of intra-service work to a more reasonable level, 35081 merits work value of 30.76 units.
4. **Summary:** Five different analyses suggest work values from 28.00 to 30.76 for this service:
 1. Median survey value is 28.
 2. Comparison to reference code 47130 suggests a work value of 29.17.
 3. The E/M building block method resulted in an estimate of 30.09.
 4. The American College of Surgeons survey suggested 29.49.
 5. The IWPUT method justified an RVW of 30.76.

Although our original letter of comment requested an RVW for 35081 of 32.10 units, the survey instrument and 4 different justification methods all suggest a slightly lower work value. After careful review of the survey results and 4 supplemental work analyses for 35081, we recommend an RVW of 28.50.

APPENDIX: IWPUT Method for work calculation of 35081

1. Intra-service work per unit time (IWPUT) ranges from 0.05 to 0.12 for virtually all surgical services.
2. Intra-service work per unit time (IWPUT) ranged from 0.050 to 0.120 in the SVS Operative Log Data Analysis presented in Table 1.
3. The median IWPUT for the 12 non-vascular operations in Table 1 is 0.082.
4. The performance of 35081 with its attendant risks of hemorrhage and cardiac complications should merit at least the median level of intra-service work per unit time. The survey intensity ratings would actually support more than a median IWPUT level.
5. The survey intra-service median time for 35081 of 202.5 minutes is substantiated by our original OR log data analysis (230 min), and by the Hospital log data requested as additional information during the survey (202 min). In fact, these data would suggest that 202.5 is a conservative (low) number.
6. The intra-service work for 35081 should equal the operative time multiplied by the median surgical IWPUT, or $202.5 \times 0.082 = 16.61$
7. The pre and post-service work for 35081 are at least typical of the average operation of large magnitude, in that patients presenting for this operation commonly suffer from symptomatic coronary artery disease, hypertension, diabetes, hyperlipidemia, obesity, and COPD.
8. The RUC survey data indicates that intra-service work represents 0.54 of total work. In other words, total work = intra-work / 0.54.
9. The total work of 35081, based on a median IWPUT value, should be $16.61 / 0.54 = 30.76$

With distal dissection completed, graft placement begins. Heparin is administered intravenously to prevent intra-arterial thrombosis during the aortic cross-clamp interval. The proximal aorta and common iliac arteries are occluded with large vascular clamps, and the aneurysm is opened. Control of back-bleeding lumbar arteries is achieved by oversewing their orifices. The inferior mesenteric artery origin is oversewn or clamped for later reimplantation. An appropriately sized prosthetic tube graft is sewn circumferentially to the normal aorta just inferior to the renal arteries. The graft is clamped just below the suture line, and the proximal aortic cross-clamp is removed slowly to check for suture line leaks. These are corrected with individual or pledgeted sutures. The distal aorta is then transected. The synthetic graft is cut to appropriate length and sutured to the distal aorta. Clamps are removed very slowly to avoid hemodynamic instability caused by the sudden restoration of flow to the lower extremities. The distal anastomosis is inspected for hemostasis, and bleeding sites are sutured. The large intestine is examined for evidence of ischemia which would necessitate implantation of the inferior mesenteric artery onto the graft. Femoral pulses are palpated to insure blood flow through the graft and iliac arteries. When the surgeon is satisfied with the technical aspects of graft placement, intravenous protamine is administered to reverse the anticoagulation. The aneurysm wall and the retroperitoneum are closed to provide a protective tissue plane between the duodenum and the synthetic graft. The intestines are returned to the abdominal cavity, and a final exploration is made searching for evidence of visceral damage or retained sponges. The abdominal wall is closed in layers.

Description of Post-Service work: Post-service work begins after skin closure in the operating room and includes application of sterile dressings, checking the extremities for pulses, transfer of the patient and monitoring equipment to a stretcher, and patient transport to the recovery unit or ICU. Postoperative orders are written, and hemodynamic stabilization is initiated. The extensive retroperitoneal dissection involved in aneurysm repair creates a large "third space" demand for blood and fluid volume replacement which must be treated aggressively on an individualized basis to avoid hypotension. Immediate post-service work also includes monitoring of blood gases, electrolytes, hemoglobin, and coagulation parameters with appropriate therapy as required. Pre-existing cardiac comorbidity usually necessitates some combination of intravenous nitroglycerine, beta-blockers, and/or pressors. As the patient rewarms and vasodilates, further individualized fluid management is required. Pulmonary comorbidity necessitates special attention to ventilator management and post-extubation respiratory therapy. Intravenous diuretics are almost always needed later in the ICU course. Post-service work also includes communication with the patient, family and health care professionals with ongoing written and telephone reports and orders. Post-ICU care focuses on assisted return to cardiopulmonary, gastrointestinal and hemodynamic homeostasis; ordering and reviewing post-operative radiographs and laboratory studies; monitoring and care of the incision; removal of all tubes and drains; antibiotics and pain management, and discharge planning. Discharge day management includes the surgeon's final examination of the patient, discussion of the likely post-hospital events, instructions for continuing care, preparation of discharge records, and communication with the referring physician and home-health agencies. Additionally, all post-discharge office visits for 90 days are part of the post-operative work for this procedure. This includes removal of sutures, wound checks, pain medication adjustments and renewal, and interpretation of imaging and laboratory tests obtained to evaluate the typical spectrum of postoperative problems.

Public Comments

30-Jun-95

Code: 35081

1995 RVUs: 22.15

Recommended RVUs: 32.10

Ratio:

Long Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta

Reference Set (y/n): Y Global Period: 090 Frequency: 15,749 Impact: 156703

Source: 2 Year: 92 Public Comment Letter: 337

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SVS

Societies Wishing to Comment: ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
35081	45.3	4.8	2.3	23.6	2.5	0	0.9	10.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
35081	17589	16818	-2.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
35081	98.3	99.1	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
35081	cardiac surgery	7.3
	cardiovascular disease	2.6
	general surgery	41.1
	group practices	3
	thoracic surgery	23.4
	vascular surgery	20.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
35081			

Public Comments

30-Jun-95

441	23.8	AORTIC ANEURYSM
444	1.2	ARTERIAL EMBOLISM AND THROMBOSI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
35081							
SVS		090	090	21.31	22.15	1.04	22.15

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
35081								
SVS	22.15	22.15	1.04	1.00	1.00	1.00	32.10	337

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
35081								
SVS	090	21.31		29		167		77
SVS	090	21.31		29		167		77

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
35081									
SVS		1.5		10	10.0		10	2.0	1.5
SVS		1.5		10	10.0		10	2.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
35081									
SVS		20		32.10	22.15	ts	n		0.074
SVS		20		32.10	22.15	ts	n		0.074

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 35082 **Global Period:** 090 **1995 RVW:** 28.82 **Recommended RVW:** 37.00

CPT Descriptor: Direct repair of aneurysm or excision (partial or total) and graft insertion for aneurysm, false aneurysm, and associated occlusive disease, for ruptured aneurysm, abdominal aorta

Source and Summary of Comment to HCFA on this service: Reevaluation of this relatively uncommon code was requested by the American Society of General Surgery (ASGS). Since the code is primarily a vascular surgery code, and since the Society for Vascular Surgery (SVS) and International Society for Cardiovascular Surgery (ISCVS) agree that the code is undervalued, the SVS/ISCVS responded at "level 1" on the Level of Interest Forms. However, we felt that surveying this code would be unproductive based on the low frequency. We chose instead to offer logical argument for the recommended RVW based on a relationship to the two more common aortic aneurysm codes that were surveyed by our societies.

1994 Frequency of Service: 4,149

CLINICAL DESCRIPTION OF SERVICE:

Vignette: No survey vignette was generated for 35082. However, a typical vignette would describe an elderly patient presenting to the Emergency Department with intense abdominal pain, hypotension, and a pulsatile abdominal mass. He would be taken immediately to the operating room where emergent repair of the aneurysm would be undertaken. His postoperative course would be far more complicated than that of an elective aortic aneurysm repair, oftentimes requiring prolonged mechanical ventilation and hemodialysis.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before surgery until the time of the procedure. For a ruptured aortic aneurysm this work includes a full-speed-ahead abbreviated history and physical exam, blood drawing, an ECG, possibly an aortic ultrasound in the ED or an emergent CT scan (these only if the patient is hemodynamically stable and there is some question about the diagnosis), a rapid explanation of the diagnosis, indication for surgery and risks with the patient and/or family, and emergent transport to the OR.

Description of Intra-Service work: If the patient is severely hypotensive, a full midline incision is made with minimal preparation, simultaneous with the induction of general anesthesia and the placement of several large bore IV catheters. For patients with more stable vital signs, these steps are undertaken rapidly, but at a slightly less frantic pace. Upon entering the abdomen, the left lobe of the liver is rapidly mobilized, the aorta is identified and cleared of surrounding soft tissue at the level of the diaphragm, and a cross-clamp is placed. The retroperitoneal hematoma around the ruptured aneurysm is entered and the proximal and distal infrarenal aorta are rapidly dissected. Distal control is obtained, and backbleeding lumbar arteries are sewn closed. The aortic prosthesis is sewn in place, clamps are removed, and the suture lines are inspected for hemostasis. Since these patients have frequently bled most of their circulating volume into the retroperitoneum, attention must be paid rapidly to correction of consumptive coagulopathy. The abdomen is closed, and the patient transferred to the ICU for ongoing resuscitation.

Description of Post-Service work: Post-service work for the ruptured aortic aneurysm is vastly more complex than that for elective aneurysm repair. Patients are hypothermic, coagulopathic, acutely anemic, and usually hemodynamically unstable. Most are treated with combinations of intravenous vasoactive agents. A multitude of problems can demand simultaneous attention. The surgeon's continued presence at the bedside is mandatory until some degree of hemodynamic stability is achieved. The postoperative ICU stay is, on average, much longer for the ruptured aneurysm patient, with a higher degree of acuity. Many patients have prolonged ventilator dependence and acute renal failure, and some develop ischemic colitis. Those that survive often spend weeks in the ICU, but in fact, those that don't survive often spend more time in an ICU bed. Once the patients leave the unit, their in-hospital recovery and outpatient recovery times are also prolonged.

SURVEY DATA: Code not surveyed**RATIONALE:**

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work; time; technical skill; and physical effort; mental effort; and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research

This relatively uncommon service is difficult to evaluate. Patients who suffer a ruptured aortic aneurysm demand instantaneous and complete attention of the surgeon, anesthesiologist, and all support staff, if the patient's life is to be saved. All ongoing activity must be interrupted in order to deal with this problem. In the finest medical centers the mortality of ruptured aortic aneurysms approaches 50%. While a few patients die rapidly in the operating room, more commonly they survive operation and are transferred to the ICU where they consume huge resource expenditures until ultimate recovery or death.

1. **Work:** The original Harvard value of 28.92 for 35082 has actually decreased over 5 years to the current value of 28.82. The 1995 RVW is 28.82, and that for elective repair of an infrarenal aneurysm is 22.15, with the ratio of ruptured to elective being $28.82 / 22.15 = 1.30$. This is a reasonable ratio based on an increased intraoperative and post-operative work. The recommended RVW for 35081 is 28.00 units, and the proportional increase for 35082 may be calculated as $28.00 \times 1.3 = 36.40$ units. Another estimate of work for 35082 is provided in the survey reported by the American College of Surgeons in their February 6, 1995 Comment to HCFA (Appendix VIII in that report). That survey recommended a work value of 37.47.

2. **Time:** The Harvard / RUC database pre-service time of 85 minutes (42 minutes prior to OR entry and 43 minutes immediately pre) is less than the survey median pre-service time for elective aneurysm of 107.5 minutes, but is probably a decent estimate for this emergent situation. The intra-time of 226 minutes is essentially equal to the 200-210 minutes we determined as the most accurate estimate of intra-service time for elective repair of an infrarenal AAA. However, the Harvard / RUC post-service time of 256 minutes is equal to the survey respondents median post-service time for elective repair of an aortic aneurysm, and is certain to be a major underestimate. Thus, we interpret pre- and intra-service time to be accurate estimates, but post-service time is far too low.

3. **Intensity:** There is virtually no other medical service who's pre-, intra-, and post-service intensity equals that of the repair of a ruptured aortic aneurysm. The patient arrives in the ED, critically ill, and a diagnosis must be established immediately. All other ongoing clinical activity must cease to care for the patient with this problem. The surgeon must maintain order in what could otherwise be a chaotic situation in the operating suite as the hypotensive patient is readied for emergent surgery, and that surgeon must be technically astute to repair a ruptured aortic aneurysm successfully. Post-operative care is most analogous to an ongoing resuscitation in the intensive care unit, and the usual prolonged ICU recovery requires the attention of an astute clinician. While intensity is difficult to evaluate quantitatively, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. The Harvard/RUC IWPUT for repair of a ruptured aortic aneurysm is 0.074, substantially less than that for TURP (0.120), cataract removal (0.110), total knee arthroplasty (0.084), and several other common services (Table 1). If 35082 is recalculated using a more realistic IWPUT of 0.09 and the Harvard/RUC intra-service time of 226, a more appropriate value of work for 35082 is obtained, at 37.67 (see appendix for an expanded discussion).

4. **Summary:** Three different analyses suggest work values from 36.40 to 37.67 for this service:

1. Constant proportion to infrarenal aortic aneurysm repair (35081) is 36.40.
2. The American College of Surgeons survey suggested 37.47.
3. The IWPUT method justifies an RVW of 37.67.

The original letter of comment from the American Society of General Surgeons recommended an RVW for 35082 of 37.35. After careful review of the 3 methods of analysis for 35082, we recommend an RVW of 37.00.

APPENDIX: IWPUT Method for work calculation for 35082

1. Intra-service work per unit time (IWPUT) ranges from 0.05 to 0.12 for virtually all surgical services.
2. Intra-service work per unit time (IWPUT) ranged from 0.050 to 0.120 in the SVS Operative Log Data Analysis presented in Table 1.
3. The median IWPUT for the 12 non-vascular operations in Table 1 is 0.082.
4. The performance of 35082 with its attendant risks of immediate death from massive hemorrhage and should merit the highest reasonable IWPUT, perhaps 0.09.
5. The Harvard / RUC intra-service time for 35082 of 226 minutes is substantiated by analogy to elective repair of an infrarenal abdominal aortic aneurysm (35081) where accurate data documents an intra-service time of 200-210 min.
6. The intra-service work for 35082 should equal the operative time multiplied by the IWPUT, or $226 \times 0.090 = 20.34$
7. The pre and post-service work for 35082 are at least typical of the elective operation (35081)
8. The RUC survey data indicates that intra-service work for the elective aortic aneurysm repair represents 0.54 of total work, and this will be a conservative estimate for that of emergent repair. In other words, total work = intra-work / 0.54.
9. The total work of 35082, based on an IWPUT of 0.09, should be $20.34 / 0.54 = 37.67$

Public Comments

30-Jun-95

Code: 35082

1995 RVUs: 28.82

Recommended RVUs: 37.35

Ratio:

Long Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta

Reference Set (y/n): Y **Global Period:** 090 **Frequency:** 3,682 **Impact:** 31407

Source: 2 **Year:** 92 **Public Comment Letter:** 185

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SVS

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
35082	63.6	8.1	10.2	27.3	1	0	0	6.2

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
35082	4430	4149	-3.2

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
35082	97.4	98.2	0.4

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
35082	cardiac surgery	4.1
	general surgery	54.1
	group practices	3.4
	thoracic surgery	18.5
	vascular surgery	15.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
35082	441	24.2	AORTIC ANEURYSM

Public Comments

30-Jun-95

789	1	OTHER SYMPTOMS INVOLVING ABDOM
997	1	OTHER COMPLICATIONS OF INTERNAL P

Harvard Data:

Comm	Modif	Packlv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
35082							
ASGS		090	090	28.92	28.82	1.00	28.82

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
35082								
ASGS	28.82	28.82	1.00	1.00	1.00	1.00	37.35	185

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
35082								
ASGS	090	28.92		42		226		85

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
35082									
ASGS		1.5		10	11.5		10	2.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
35082									
ASGS		10		37.35	28.82	gs	3		0.074

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 35091 **Global Period:** 090 **1995 RVW:** 28.10 **Recommended RVW:** 36.50

CPT Descriptor: Direct repair of aneurysm or excision (partial or total) and graft insertion for aneurysm, false aneurysm, and associated occlusive disease, for abdominal aorta involving visceral vessels (mesenteric, celiac, renal)

Source and Summary of Comment to HCFA on this service: Reevaluation of this relatively uncommon code was requested by the American Society of General Surgery (ASGS). Since the code is primarily a vascular surgery code, and since the Society for Vascular Surgery (SVS) and International Society for Cardiovascular Surgery (ISCVS) agree that the code is undervalued, the SVS/ISCVS responded at "level 1" on the Level of Interest Forms. However, we felt that surveying this code would be unproductive based on the low frequency. We chose instead to offer logical argument for the recommended RVW based on a relationship to the two more common aortic aneurysm codes that were surveyed by our societies.

1994 Frequency of Service: 1,780

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: No survey was performed for this service. However, a typical vignette would be the following: A 71 year old hypertensive asymptomatic 5'10" male weighing 95 kilograms with a history of a myocardial infarction and a 50 pack-year history of smoking has a 6.5 cm abdominal aortic aneurysm which was diagnosed by ultrasound. Extensive pre-op work-up is done, including a CT scan which reveals that the aneurysm extends proximally to the level of the superior mesenteric artery. An arteriogram is performed to detail the upper aortic arterial anatomy. Pre-operative invasive monitoring includes insertion of a Swan-Ganz catheter, arterial line, Foley catheter, NG tube and sequential compression devices applied. The operation is performed through a thoracoretroperitoneal incision with separate reimplantation of the left renal artery. The patient is in the ICU on a ventilator for 48 hours postoperatively and requires real-time hemodynamic monitoring, close monitoring of urinary output, diuretic support, and fluid management. The patient is transferred to the floor after 72 hours. The remainder of his postoperative course is uneventful and he is discharged to home on the 10th postoperative day.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before surgery until the time of the procedure. This work includes review of hospital admission workup with special attention to cardiopulmonary and hematologic status; review of CT scans, ultrasound studies, arteriograms, and laboratory tests; communication with referring physician, cardiologist, anesthesiologist and other health care professionals as necessary; review of indications, risks and benefits of surgery with patient and family; signature of informed consent, and preview of expected hospital course, pain management, discharge plans etc. with patient and family. Pre-service work also includes changing into OR scrubs, hand washing, and waiting for surgery; supervision of positioning, skin preparation, and draping of the patient; and ensuring that surgical instruments and necessary supplies are present and available in the operative suite. Surgical presence is also required as the anesthesiology team proceeds with lumbar epidural catheter placement and testing, insertion of a Swan-Ganz catheter, insertion of arterial pressure line, and induction of general endotracheal anesthesia.

Description of Intra-Service work: (note: This operation differs from 35081 and 35102 in that more dissection is required in the upper abdomen, and transection of the diaphragm with entry into the chest is commonly required for proximal control. Depending on the particular case, one or more additional arterial anastomoses must be completed.) Skin incision is usually through a thoracoretroperitoneal approach which requires special positioning with the patient lying with his right side down and his left arm extended. The aorta is dissected free of attachments proximally until a segment of non-aneurysmal vessel is reached, and the diaphragm is often divided to accomplish this proximal exposure. The mesenteric and renal vessels are identified to avoid injury. The distal aortic exposure is completed as in the other aortic aneurysm operations. The patient is heparinized, and proximal and distal aortic clamps applied. The aneurysm is entered, and control of backbleeding vessels is achieved. Cold electrolyte solution is infused in the renal artery orifices to

minimize ischemic insult. The proximal aortic anastomosis is sewn rapidly to minimize visceral ischemic time. Mesenteric and renal arteries are sewn to the prosthesis as required, and reperfusion of these organs is accomplished as quickly as possible. The aortic cross-clamp is moved onto the body of the prosthesis allowing reperfusion of the viscera, and the distal aortic anastomosis is completed. The cross-clamp is released slowly to avoid hypotension related to rapid reperfusion of ischemic limbs. Anastomoses are checked for hemostasis which is secured with individual or pledgeted sutures. Femoral pulses are palpated to insure blood flow through and beyond the aortic prosthesis. Heparin anticoagulation is reversed with protamine. Abdominal closure is accomplished in three layers. Since there is no separate CPT code for an aneurysm which involves the visceral arteries and also extends into the iliac vessels, any extra work associated with distal extent of this aneurysm into the iliac arteries is also included in this code.

Description of Post-Service work: Post-service work begins after skin closure in the operating room and includes application of sterile dressings, checking the extremities for pulses, transfer of the patient and monitoring equipment to a stretcher, and patient transport to the ICU. Postoperative orders are written, and hemodynamic stabilization is initiated. The extensive retroperitoneal dissection involved in aneurysm repair creates a large "third space" demand for blood and fluid volume replacement which must be treated aggressively on an individualized basis to avoid hypotension. Immediate post-service work also includes monitoring of blood gases, electrolytes, hemoglobin, and coagulation parameters with appropriate therapy as required. Pre-existing cardiac comorbidity necessitates some combination of intravenous nitroglycerine, beta-blockers, and/or pressors. As the patient rewarms and vasodilates, further individualized fluid management is required. Pulmonary comorbidity necessitates special attention to ventilator management and post-extubation respiratory therapy. Intravenous diuretics are almost always needed later in the ICU course. Post-service work also includes communication with the patient, family, and health care professionals with ongoing written and telephone reports and orders. Post-ICU care focuses on assisted return to cardiopulmonary, gastrointestinal and hemodynamic homeostasis; ordering and reviewing post-operative radiographs and laboratory studies; monitoring and care of the incision; removal of all tubes and drains; antibiotics and pain management, and discharge planning. Discharge day management includes the surgeon's final examination of the patient, discussion of the likely post-hospital events, instructions for continuing care, preparation of discharge records, and communication with the referring physician and home-health agencies. Additionally, all post-discharge office visits for 90 days are part of the post-operative work for this procedure. This includes removal of sutures, wound checks, pain medication adjustments and renewal, and interpretation of imaging and laboratory tests obtained to evaluate the typical spectrum of postoperative problems.

SURVEY DATA: Code not surveyed

RATIONALE:

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work; time; technical skill; and physical effort; mental effort; and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research

The recommended increase in RVW for 35091 is based upon maintenance of the relative work of this service among the other aortic aneurysm repair codes in this family.

The relatively uncommon service includes both those aortic aneurysm repairs which terminate at the distal aorta and those which extend into the iliac arteries. Patients with this diagnosis are usually referred to tertiary care centers where their operations are performed by teams of surgeons and anesthesiologists with special training and experience in the repair of supra-renal aortic aneurysms. The risk of perioperative renal failure, mesenteric ischemia, spinal cord ischemia, and cardiac complications is substantially increased when aneurysmal degeneration involves the visceral

segment of the abdominal aorta. The original RVW for this service was 24.60, and it increased in 1993 to 28.10. No further changes in RVW have taken place.

1. **Work:** The 1995 RVW for 35091 is 28.10, and that for elective repair of an infrarenal aneurysm (35081) is 22.15, with the ratio of 35091 to 35081 being $28.10 / 22.15 = 1.27$. Based on the significant extra work involved in 35091, our societies estimate this ratio as being too low, but one method to compute a proportional RVW for 35091 is to multiply the recommended RVW for 35081 (28.00 units) by 1.27. Thus, a proportional increase for 35091 is $28.10 \times 1.27 = 35.69$. Another estimate of work for 35091 is provided in the survey reported by the American College of Surgeons in their February 6, 1995 Comment to HCFA (Appendix VIII in that report). That survey recommended a work value of 36.53.

2. **Time:** The Harvard / RUC database pre-service time of 93 minutes (53 minutes prior to OR entry and 40 minutes immediately pre) is less than the survey median pre-service time for elective infrarenal aneurysm repair of 107.5 minutes. This probably is an underestimate based on the extensive pre-operative workup and extra pre-operative positioning required for this procedure. The Harvard / RUC intra-time of 249 minutes is essentially equal to the 240 minute median survey time for 35102 (repair of infrarenal AAA with bifurcated graft), a significantly less involved aortic operation. Finally, the Harvard / RUC post-service time of 255 minutes is 5 minutes more than that for 35081 or 35102. We judge this to be accurate or slightly low. Thus, we interpret the existing Harvard / RUC pre- and intra-service times to be underestimates, and post-service time to be slightly low or accurate. Considered together, the current time data for 35091 is almost certainly too low.

3. **Intensity:** Intensity of most arterial reconstructive vascular procedures is quite high due to potential for intraoperative catastrophe such as major hemorrhage, and due to potential for major postoperative complications such as myocardial infarction. The intensity of 35091 is greater than that for repair of infrarenal aortic aneurysms (35081, 35012) due to the requirement for dissection at and above the origins of the visceral vessels, the need for rapid and effective arterial anastomotic technique to minimize the risk of visceral ischemia, and the increased risk of post-operative renal failure, mesenteric ischemia, and spinal cord ischemia. While intensity is difficult to evaluate quantitatively, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. The IWPUT for 35091 in the Harvard / RUC database is only 0.058 (Summary of work and time estimates for services undergoing investigation, AMA RUC 6/8/95). This is less than that for TURP (0.120), cataract removal (0.110), total knee arthroplasty (0.084), and several other common services (Table 1). If 35091 is recalculated using the median IWPUT from the SVS study (0.082), and the Harvard / RUC intra-service time (249 min), a more accurate reflection of intra-service intensity is reached. By this technique, intra-work is $249 \times 0.082 = 20.42$ units. Since intra-work represents 0.51 of total work according to the Harvard / RUC data, the total work is $20.42 / 0.51 = 40.04$ units (see Appendix for an expanded discussion). Thus, by adjusting the intensity of intra-service work to a more reasonable level, 35091 merits a work value of 40.04.

4. **Summary:** Three different analyses suggest work values from 35.69 to 40.04 for this service:

1. Constant proportion to infrarenal aortic aneurysm repair (35081) is 35.69.
2. The American College of Surgeons survey suggested 36.53.
3. The IWPUT method justifies an RVW of 40.04.

The original letter of comment from the American Society of General Surgeons recommended an RVW for 35091 of 29.61 units. However, three different methods suggest a higher work value is justified. Thus, we recommend for CPT 35091 an RVW of 36.50.

APPENDIX: IWPUT Method for work calculation for 35091

1. Intra-service work per unit time (IWPUT) ranges from 0.05 to 0.12 for virtually all surgical services.
2. Intra-service work per unit time (IWPUT) ranged from 0.050 to 0.120 in the SVS Operative Log Data Analysis presented in Table 1.
3. The median IWPUT for the 12 non-vascular operations in Table 1 was 0.082.
4. The performance of 35091 with its attendant risks of hemorrhage, renal failure, and cardiac complications should merit at least the median level of intra-service work per unit time.
5. The Harvard / RUC intra-service time for 35091 of 249 minutes is substantiated by our accurate value of 200-210 minutes for 35081, and a firm estimate of 240-250 minutes for 35102. In fact, these data would suggest that 249 may lie on the low end of the true range.
6. The intra-service work for 35091 should equal the operative time multiplied by the median surgical IWPUT, or $249 \times 0.082 = 20.42$.
7. The pre and post-service work for 35091 are at least that of 35081 and 35102, in that patients presenting for this operation commonly suffer from symptomatic coronary artery disease, hypertension, diabetes, hyperlipidemia, obesity, and COPD. In addition, patients undergoing 35091 are more likely to suffer severe post-operative complications of renal failure, mesenteric ischemia, and spinal cord ischemia.
8. The Harvard / RUC data indicates that intra-service work represents 0.51 of total work (14.32/28.10). In other words, total work = intra-work / 0.51.
9. The total work for 35091, based on the median IWPUT is $20.42 / 0.51 = 40.04$.

Public Comments

30-Jun-95

Code: 35091

1995 RVUs: 28.1

Recommended RVUs: 29.61

Ratio:

Long Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)

Reference Set (y/n): Y **Global Period:** 090 **Frequency:** 1,660 **Impact:** 2507

Source: 5 **Year:** 93 **Public Comment Letter:** 185

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SVS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
35091	42.3	1.9	1.9	34.6	1.9	0	1.9	13.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
35091	1631	1780	4.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
35091	98.5	99	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
35091	cardiac surgery	5.3
	cardiovascular disease	2.4
	general surgery	34.3
	group practices	6.4
	thoracic surgery	25.3
	vascular surgery	23.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
35091			

Public Comments

30-Jun-95

440	1.4	ATHEROSCLEROSIS
441	20.2	AORTIC ANEURYSM
442	7.2	OTHER ANEURYSM
444	2.4	ARTERIAL EMBOLISM AND THROMBOSI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
35091							
ASGS		090	090	24.60	28.10	1.14	24.68

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
35091								
ASGS	28.10	28.10	1.00	1.14	1.00	1.00	29.61	185

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
35091								
ASGS	090	24.60		53	*	249		80

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
35091									
ASGS	*	1.5		10	12.0	*	10	2.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
35091									
ASGS	*	10		29.61	28.10	gs	3		0.058

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 35102 Global Period: 090 1995 RVW: 23.44 Recommended RVW: 31.50

CPT Descriptor: Direct repair of aneurysm or excision (partial or total) and graft insertion for aneurysm, false aneurysm, and associated occlusive disease, for abdominal aorta involving iliac vessels (common, hypogastric, external)

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 11 vascular surgeons designed a study to measure the major component of work for vascular surgical procedures. Accurate intraoperative (skin-to-skin) surgery times of commonly performed vascular and non-vascular procedures were collected from operative logs and computer databases at ten hospitals, both private and University. Median intra-service time and intra-service work per minute (IWPUT) were calculated (Table 1). The results of this study identified the intra-service work of code 35102 to be significantly undervalued based on a comparison with typical "signature" procedures from many other surgical disciplines. This comparison of intra-service work formed the basis for choosing 35102 to be surveyed for all aspects of work in the five year review.

1994 Frequency of Service: 8,816

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71 year old hypertensive asymptomatic 5'10" male weighing 95 kilograms with a history of a myocardial infarction and a 50 pack-year history of smoking has a 6.5 cm infrarenal abdominal aortic aneurysm by ultrasound. Extensive pre-op work-up is done. Appropriate invasive monitoring is done with insertion of a Swan-Ganz catheter, arterial line, Foley catheter, NG tube and sequential compression devices applied. Standard aortic aneurysmectomy with a tube graft is performed. The patient is in the ICU on a ventilator for 48 hours postoperatively and requires real-time hemodynamic monitoring, close monitoring of urinary output, diuretic support, and fluid management. The patient is transferred to the floor after 72 hours. The remainder of his postoperative course is uneventful and he is discharged to home on the 10th postoperative day.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before surgery until the time of the procedure. This work includes review of hospital admission workup with special attention to cardiopulmonary and hematologic status; review of CT scans, ultrasound studies, arteriograms, and laboratory tests; communication with referring physician, cardiologist, anesthesiologist and other health care professionals as necessary; review of indications, risks and benefits of surgery with patient and family; signature of informed consent; and preview of expected hospital course, pain management, discharge plans etc. with patient and family. Pre-service work also includes changing into OR scrubs, hand scrubbing, and waiting for surgery; supervision of positioning, skin preparation, and draping of the patient; and insuring that surgical instruments and necessary supplies are present and available in the operative suite. Surgical presence is also required as the anesthesiology team proceeds with lumbar epidural catheter placement and testing, insertion of a Swan-Ganz catheter, insertion of arterial pressure line, and induction of general endotracheal anesthesia.

Description of Intra-Service work: (note: This operation differs from 35081 in that more dissection is required in the pelvis, and one more arterial anastomosis must be completed.) The abdomen is incised from the xiphoid to the pubis, the peritoneal cavity is opened, and general exploration is made for the presence of tumors, gall bladder abnormalities, adhesions, and correct positioning of the NG tube. The intestines are reflected to the right upper quadrant of the abdominal cavity. A self-retaining retractor is connected to the operating table and appropriate blades are placed to achieve exposure of the aorta. The retroperitoneum and ligament of Treitz are incised, and the duodenum is reflected away from the aorta. The aneurysm is exposed proximally until normal aortic tissue is encountered at the level of the left renal vein. The renal vein is mobilized carefully, and the aorta at this level is mobilized sufficiently to prepare for its subsequent division. The upper portion of the aneurysm is inspected to insure that no unsuspected accessory renal arteries arise from its surface, and the inferior mesenteric artery, which arises from the body of the aneurysm, is identified and inspected for patency.

Attention is then turned to the iliac arteries to determine the distal extent of aneurysm involvement. When aneurysmal tissue extends into these vessels, a bifurcated graft must be used such that the graft limbs extend to normal arterial tissue. If normal distal iliac arteries can be reached safely from within the abdomen, distal dissection is carried directly into the pelvis with exposure of the common, external, and internal iliac arteries as required. Special attention is paid to avoiding ureteral and iliac vein injuries during the pelvic dissection since these can be life threatening complications. If the aneurysm extends beyond a region that can be reached safely from the abdominal incision, the iliacs are dissected enough to allow suture ligation distally. Separate incisions are then performed in each groin for exposure of the femoral arteries as target vessels for distal anastomosis. Retroperitoneal tunnels are fashioned to carry the graft limbs from the pelvic inlet, under the inguinal ligament, to the femoral triangle.

With the distal dissection completed, graft placement begins. Heparin is administered intravenously to prevent intra-arterial thrombosis during the aortic cross-clamp interval. The proximal aorta and distal iliacs are occluded with large vascular clamps, and the aneurysm is opened. Control of back-bleeding lumbar arteries is achieved by oversewing their orifices. The inferior mesenteric artery origin is oversewn or clamped for later reimplantation. An appropriately sized bifurcated synthetic graft is sewn circumferentially to the normal proximal aorta just inferior to the renal arteries. The graft is clamped just below the suture line, and the proximal aortic cross-clamp is removed slowly to check for suture line leaks. These are corrected with individual or pledgeted sutures. Attention is directed to the iliac (or femoral) arteries which are prepared for anastomosis of the distal graft limbs. Depending on the site of distal anastomosis, either the common iliac, external plus internal iliac, or the femoral bifurcation arteries are clamped. The target artery is opened. The prosthetic limb is cut to the appropriate length and sutured to the artery. Clamps are removed slowly to avoid hemodynamic instability caused by the sudden restoration of flow to the limb. The suture line is inspected for hemostasis with correction of any leaks. The second iliac (or femoral) artery anastomosis is performed in a similar manner. The large intestine is examined for evidence of ischemia which would necessitate implantation of the inferior mesenteric artery onto the graft. Femoral pulses are palpated to insure blood flow through and beyond the aortic prosthesis. When the surgeon is satisfied with the technical aspects of graft placement, intravenous protamine is administered to reverse the anticoagulation. The aneurysm wall and the retroperitoneum are closed to provide a protective tissue plane between the duodenum and the synthetic graft. The intestines are returned to the abdominal cavity, and a final inspection is made for visceral damage or retained sponges. The abdominal wall is closed in layers. If femoral incisions have been performed, these are closed in layers.

Description of Post-Service work: Post-service work begins after skin closure in the operating room and includes application of sterile dressings, checking the extremities for pulses, transfer of the patient and monitoring equipment to a stretcher, and patient transport to the recovery unit or ICU. Postoperative orders are written, and hemodynamic stabilization is initiated. The extensive retroperitoneal dissection involved in aneurysm repair creates a large "third space" demand for blood and fluid volume replacement which must be treated aggressively on an individualized basis to avoid hypotension. Immediate post-service work also includes monitoring of blood gases, electrolytes, hemoglobin, and coagulation parameters with appropriate therapy as required. Pre-existing cardiac comorbidity usually necessitates some combination of intravenous nitroglycerine, beta-blockers, and/or pressors. As the patient rewarms and vasodilates, further individualized fluid management is required. Pulmonary comorbidity necessitates special attention to ventilator management and post-extubation respiratory therapy. Intravenous diuretics are almost always needed later in the ICU course. Post-service work also includes communication with the patient, family and health care professionals with ongoing written and telephone reports and orders. Post-ICU care focuses on assisted return to cardiopulmonary, gastrointestinal and hemodynamic homeostasis; ordering and reviewing post-operative radiographs and laboratory studies; monitoring and care of the incision(s); removal of all tubes and drains; antibiotics and pain management, and discharge planning. Discharge day management includes the surgeon's final examination of the patient, discussion of the likely post-hospital events, instructions for continuing care, preparation of discharge records, and communication with the referring physician and home-health agencies. Additionally, all post-discharge office visits for 90 days are part of the post-operative work for this procedure. This includes removal of sutures, wound checks, pain medication adjustment and renewal, and interpretation of imaging and laboratory tests obtained to evaluate the typical spectrum of postoperative problems.

SURVEY DATA:**Specialty:** Society for Vascular Surgery (SVS) / International Society for Cardiovascular Surgery (ISCVS)**Sample Size:** 58 **Response Rate:** 69% (40/58) **Median Survey RVW:** 30.74**25th percentile RVW:** 29 **75th percentile RVW:** 35 **Low:** 19.5 **High:** 65**Median Pre-Service Time:** 107.5 **Median Intra-Service Time:** 240**25th Percentile Intra-Svc Time:** 191 **75th Percentile Intra-Svc Time:** 277 **Low:** 120 **High:** 360

Median Post-Service Time:	<u>Total time</u>	<u>Number of Visits</u>
Day of Procedure:	60	
ICU:	60	4
Other Hospital:	90	7
Office:	40	2

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1995 RVW</u>
1.	47130	Hepatectomy, total right lobe	31.56
2.	43631	Gastrectomy, partial, distal; with gastroduodenostomy	18.10

RELATIONSHIP OF CODE UNDER SURVEY TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service your are rating to the key reference services listed above.

Construction of a reference service table (Table 3) for the 5 year reevaluation survey was difficult for the vascular surgery codes since most of the vascular procedures on the MPC list were submitted for reevaluation. The SVS/ISCVS advisors asked the RUC administrative staff for assistance with this table, and we were referred to Dr. Kwass, chair of the RUC research subcommittee and also chair of the workgroup to which these codes are assigned. The recommendation was to choose reference services from the general surgery codes on the MPC list since 1) all vascular surgeons have completed a full 5 year categorical general surgery residency and are therefore familiar with general surgery cases, and 2) while we are "vascular surgeons" by dint of concentrated training or fellowship programs in vascular surgery, many vascular surgeons have practices which include general surgery cases. Thus, while the reference services are related to the code being surveyed by pre-service work, operative time, intensity, and magnitude of the operation; in addition to post-service work and global periods, the actual operations may be dissimilar.

Comparison to 47130: Pre-service activities for major operations have similar intensities, allowing comparisons of work to be judged on the basis of time. The median pre-service time for 35102 by survey is 107.5 min. while that for 47130 is 79 min. (calculated from "Summary of Work and Time Estimates" provided by the RUC on 6/8/95 as pre (before OR) time of 49 min plus 30 min (1/2 of the 60 min immediate PrePost). The extra preservice time involved in 35102 may be attributed to the greater number of comorbidities, cardiac, pulmonary, and others, found in the vascular patient. The vignette patient, having had a previous myocardial infarction, is a true

representative of the aortic aneurysm cohort. Preparation time in the OR is similar for 35102 and 47130. Both require full hemodynamic monitoring typically associated with operations which may induce physiologic instability. Thus, pre-service work of 107.5 minutes for 35102 is 28.5 minutes (36%) greater than 47130. The median survey intra-service time of 240 min. for 35102 is 8 min., or 3% greater than the 232 min. intra-service time of 47130. Median post-service time on the day of surgery for 35102 of 60 min. is 20 min. more than the 40 min. same day post-service for 47130. Both codes have 4 ICU visits with a total of 60 min. (The Harvard / RUC data suggest that 47130 has 4 x 10 minute ICU visits, but the survey suggests 47130 has 4 x 15 min visits. We used 4 x 15 minutes for 47130, giving any potential bias to the comparison code). 35102 has 7 post-ICU hospital visits consuming 90 minutes while 47130 has 11 hospital visits requiring 110 minutes. 35102 has 2 x 20 minute post-discharge office visits while 47130 has 4.5 x 15 minute office visits. Overall, 35102 has 250 minutes of post-operative care in the global period compared to 278 minutes of post-service time for 47130. Thus, 35102 has 10% less post-service time than the comparison service.

Intensity Comparison to 47130: The mental effort and judgment, technical skill and physical effort, and psychological stress involved in 35102 is similar to or greater than that of 47130. Both procedures lie in the upper spectrum of surgical skill and effort for surgeons in general. For those whose practices are not focused on liver or aneurysm surgery, both procedures can be very taxing and fraught with challenges. For surgeons who specialize in hepatic or vascular surgery, these 2 procedures are considered challenging but not extraordinary. Both operations usually proceed without undue cardiovascular instability, but truly complex intraoperative situations, such as massive hemorrhage, does occur with with a low but real frequency.

Summary of comparison to 47130: 35102 has 36% more pre-service work, 3% more intra-service work, and 10% less post-service work than 47130. The 1995 work value for 47130 is 31.56 units. Sixty percent of the total work for this service is intra-service work, making the intraservice component 18.94 units and the pre+post-service work 12.62 units. Pre-service work represents approximately 22% of the sum of pre and post service work for this service. Assuming 35102 has 36% more pre-service work and pre-service work is 22% of pre + post, then 35102 has 3.78 pre-service work units ($12.62 * 0.22 * 1.36$). Since 35102 has 3% more intraservice work, the relative intraservice work would be 19.51 units ($18.94 * 1.03$). Since 35102 has 10% less post-service work, the relative post-service work is 8.86 units ($12.62 * 0.78 * 0.90$). Thus, by using a step-by-step comparison to 47130, the total work for 35102 should be the sum of 3.78 pre-service units, plus 19.51 intra-service units, plus 8.86 post service units, or **32.15 units**.

Comparison to E/M Codes: The work of 35102 may be calculated as the sum of the following E/M services, using intensive care codes as the best comparison to the complex intra-service work involved in aortic aneurysm repair:

<u>Service</u>	<u>Time</u>	<u>E/M Code</u>	<u>RVW</u>
Pre-service	107.5	99215	1.51
Intra-service	240	99291 + 99292 x 6	14.68
Post-day of proc	60	99291	3.64
POD #1 ICU	30	99291	3.64
POD#2 ICU	15	99233	1.25
POD#3 ICU	15	99233	1.25
POD #4,5	15	99232 x 2	1.76
POD #6-9	10	99231 x 4	2.04
POD #10 Disch	20	99238	1.06
Office x2	40	99213	1.10
Total:			31.93

Thus, by using an E/M reference service building-block method the work of 35102 should be **31.93 units**.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work; time; technical skill; and physical effort; mental effort; and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research

The recommended increase in RVW is based upon improvements in the accuracy of existing Harvard work and intensity data for this code.

1. Work: The Harvard work value was originally estimated at 23.67 units by a panel without substantial participation by vascular surgeons. The RVW was decreased by 4% in 1992 then increased by 3% in 1993 to its current value of 23.44. No further adjustments have been made since 1993. The median work survey value for 35102 is 30.74, and even the 25th percentile RVW of 29 is 24% greater than the current 1995 RVW. The key reference service comparison suggests a value of 32.15, and the E/M building-block calculation indicates a value of 31.93. In addition, the work survey reported by the American College of Surgeons in their February 6, 1995 Comment to HCFA (Appendix VIII in that report) suggests a work value for this service of 32.76.

2. Intensity: Intensity of most arterial reconstructive vascular procedures is quite high due to potentially preventable intraoperative catastrophes such as major hemorrhage, and to potential for major postoperative complications such as myocardial infarction. The intensity of 35102 was rated as having a median mental effort value of 4, median technical skill value of 4, and median psychological stress value of 4. While intensity is difficult to evaluate quantitatively, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. In contrast to the high intensity judged by the survey respondents, the IWPUT for 35102 in 1995 is only 0.044 when calculated using the 1995 RVW and the accurate intra-service times from our SVS 10-hospital OR data analysis (Table 1). Likewise, RUC / Harvard IWPUT for this operation is only 0.053 according to the Summary of Work and Time Estimates for Services Undergoing Investigation (AMA RUC 6/8/95). This is less than that for TURP (0.120), cataract removal (0.110), total knee arthroplasty (0.084), and several other common services (Table 1). If 35102 is recalculated using the median IWPUT from the SVS study (0.082), a more accurate reflection of intra-service intensity is employed. By this technique, intra-service work is $240 \times 0.082 = 19.68$ units. Since intra-work represents 0.58 of total work per the current survey, the total work is $19.68 / 0.58 = 33.93$ units (see Appendix for an expansion of this argument). Thus, by adjusting the intensity of intra-service work to a more reasonable level, 35102 merits a work value of 33.93.

3. Summary: Five different analyses suggest work values from 30.74 to 33.93 for this service:

1. Median survey value is 30.74.
2. Comparison to reference code 47130 suggests a work value of 32.15.
3. The E/M building block method resulted in an estimate of 31.93.
4. The American College of Surgeons survey suggested 32.76.
5. The IWPUT method justified an RVW of 33.93.

Although our original letter of comment requested an RVW for 35102 of 37.00, the survey instrument and 4 different justification methods suggest a lower work value. After careful review of the survey results and 4 supplemental work analyses for 35102, we recommend an RVW of 31.5.

APPENDIX: IWPOT Method for work calculation of 35102

1. Intra-service work per unit time (IWPOT) ranges from 0.05 to 0.12 for virtually all surgical services.
2. Intra-service work per unit time (IWPOT) ranged from 0.050 to 0.120 in the SVS Operative Log Data Analysis presented in Table 1.
3. The median IWPOT for the 12 non-vascular operations in Table 1 was 0.082.
4. The performance of 35102 with its attendant risks of hemorrhage and cardiac complications should merit at least the median level of intra-service work per unit time. The survey intensity ratings would actually support more than a median IWPOT level.
5. The survey intra-service median time for 35102 of 240 minutes is substantiated by our original OR log data analysis (296 min), and by the Hospital log data requested as additional information during the survey (239 min). In fact, these data would suggest that 240 may lie on the low end of the true range.
6. The intra-service work for 35102 should equal the operative time multiplied by the median surgical IWPOT, or $240 \times 0.082 = 19.68$
7. The pre and post-service work for 35102 are at least typical of the average operation of large magnitude, in that patients presenting for this operation commonly suffer from symptomatic coronary artery disease, hypertension, diabetes, hyperlipidemia, obesity, and COPD.
8. The RUC survey data indicates that intra-service work represents 0.58 of total work. In other words, total work = intra-work / 0.58.
9. The total work for 35102, based on the median IWPOT is $19.68 / 0.58 = 33.93$

Public Comments

30-Jun-95

Code: 35102 **1995 RVUs:** 23.44 **Recommended RVUs:** 37.00 **Ratio:**

Long Descriptor: Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 7,784 **Impact:** 105551

Source: 5 **Year:** 93 **Public Comment Letter:** 337

Reference Services:

CMD Comment:

Societies Wishing to Survey: SVS

Societies Wishing to Comment: ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
35102	38.7	2.4	4.7	20.8	4.6	0.5	1.5	11.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
35102	8623	8816	1.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
35102	98.2	99.2	0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
35102	cardiac surgery	5.6
	cardiovascular disease	2.5
	general surgery	38.7
	group practices	4.1
	thoracic surgery	19.9
	vascular surgery	27

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
35102			

Public Comments

30-Jun-95

440	2.4	ATHEROSCLEROSIS
441	21.4	AORTIC ANEURYSM
442	5.4	OTHER ANEURYSM
444	3.3	ARTERIAL EMBOLISM AND THROMBOSI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
35102							
SVS		090	090	23.67	23.44	0.99	22.67

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
35102								
SVS	23.44	23.44	0.96	1.03	1.00	1.00	37.00	337

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
35102								
SVS	090	23.67		47		247		70

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
35102									
SVS		1.5		10	11.5		10	2.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
35102									
SVS		10		37.00	23.44	gs	3		0.053

the diameter of the artery. If a shunt has been used, it is removed just prior to completion of the arterial closure. Vascular clamps are released with reinitiation of blood flow, and hemostasis of the suture line is achieved. The incision is closed in 3 layers.

Description of Post-Service work: Post-service work begins after skin closure in the operating room and includes application of sterile bandages, waiting for emergence from anesthesia, and confirmation that the patient has an intact neurologic status. Once this is assured, the patient is transferred to the recovery room where postoperative orders are written. Immediate postoperative treatment commonly includes the use of intravenous vasopressors or antihypertensives to normalize blood pressure since significant blood pressure irregularity is a common finding for up to 24 hours after this operation. The surgeon reviews ECG, blood gas, and other blood test results, and monitors neurologic status. The family, referring physician, and consultant physicians are contacted. In-hospital post-service time includes all subsequent ICU and hospital visits, continued regulation of blood pressure, monitoring and care of the incision; monitoring, care, and removal of all tubes and drains; and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the likely post-hospital events, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for 90 days are part of the post-operative work. This includes removal of sutures, evaluation of periodic imaging studies and laboratory reports, and pain medication adjustments if necessary.

SURVEY DATA:

Specialty: Society for Vascular Surgery (SVS) / International Society for Cardiovascular Surgery (ISCVS)

Sample Size: 58 **Response Rate:** 69% (40/58) **Median Survey RVW:** 18

25th percentile RVW: 17.4 **75th percentile RVW:** 20 **Low:** 14 **High:** 35

Median Pre-Service Time: 90 **Median Intra-Service Time:** 143.5

25th Percentile Intra-Svc Time: 120 **75th Percentile Intra-Svc Time:** 180 **Low:** 60 **High:** 210

Median Post-Service Time:	<u>Total time</u>	<u>Number of Visits</u>
Day of Procedure:	40	
ICU:	30	2
Other Hospital:	30	2
Office:	30	2

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1995 RVW</u>
1.	35606	Bypass graft, with other than vein, carotid-subclavian	17.40
2.	35372	Thromboendarterectomy, w/w/o patch, deep profunda	12.28

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 35301 **Global Period:** 090 **1995 RVW:** 15.95 **Recommended RVW:** 18.00

CPT Descriptor: Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 11 vascular surgeons designed a study to measure the major component of work for vascular surgical procedures. Accurate intraoperative (skin-to-skin) surgery times of commonly performed vascular and non-vascular procedures were collected from operative logs and computer databases at ten hospitals, both private and University. Median intra-service time and intra-service work per minute (IWPUT) were calculated (Table 1). The results of this study identified the intra-service work of code 35301 to be significantly undervalued based on a comparison with typical "signature" procedures from many other surgical disciplines. This comparison of intra-service work formed the basis for choosing 35301 to be surveyed for all aspects of work in the five year review.

1994 Frequency of Service: 71,538

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year old male with a history of a left cerebral hemisphere TIA is diagnosed with an 85% stenosis of his left internal carotid artery and a 60% stenosis of his right internal carotid artery, upon noninvasive vascular evaluation. Appropriate invasive monitoring is done with insertion of an arterial line, Foley catheter, and sequential compression devices applied. After appropriate positioning of the patient, he undergoes a standard left carotid endarterectomy utilizing cerebral perfusion precautions. The patient becomes hypertensive in the recovery room and receives oral pharmacologic management for 24 hours. The post-op course is uneventful and he is discharged from the hospital on the third post operative day.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before surgery until the time of the procedure. This includes review of the hospital admission workup with special attention to cardiac comorbidity which is ubiquitous among those with carotid atherosclerosis; review of CT scans, duplex ultrasound studies, arteriograms, and laboratory tests; communication with referring physician, cardiologist, anesthesiologist and other health care professionals as necessary; review of indications, risks and benefits of surgery with patient and family; signature of informed consent; and preview of expected hospital course, pain management, discharge plans etc. with patient and family. Other pre-operative services include dressing, scrubbing, and waiting for surgery; supervision of patient positioning and skin preparation, and ensuring that necessary surgical instruments and supplies are available. Surgical presence is also required as the anesthesiology team proceeds with induction of general endotracheal anesthesia and insertion of an arterial pressure line.

Description of Intra-Service work: The neck is incised along the anterior border of the sternocleidomastoid muscle, and the soft tissue is dissected away from the carotid sheath. The common carotid, internal carotid and external carotid arteries are exposed, mobilized, and encircled taking care not to injure the vagus or hypoglossal nerves. Systemic anticoagulation is administered, the arteries are occluded, and the common carotid artery is opened longitudinally. This incision is carried across the bifurcation, onto the internal carotid artery, and beyond the terminus of the obstructive plaque. Intraoperative EEG recording is frequently used in this portion of the operation to follow brain function as the blood flow is interrupted. A shunt may be inserted for cerebral perfusion if required. Using 2 to 3.5 power magnification glasses, the surgeon dissects the plaque from the common, external, and internal carotid arteries. The endarterectomy site is inspected carefully searching for residual remnants of plaque which are removed. Fine sutures are used to tack down any distal shelf at the endpoint of the endarterectomy in the internal carotid. When the surgeon is confident that no loose segments of plaque remain within the vessel, the arteriotomy is closed. Oftentimes a diamond-shaped synthetic or venous patch is incorporated in this arterial suture line to increase

RELATIONSHIP OF CODE UNDER SURVEY TO KEY REFERENCE SERVICE(S):

Although 35606 is not on the MPC list, it was chosen for inclusion on our reference service list (Table 3) because; 1) it has been used successfully as a reference service on previous RUC surveys conducted by our societies for vascular reconstructions in the neck, and 2) the work involved in 35606 very closely approximates that of 35301. Indeed, 34 of 40 survey respondents chose 35606 as the reference code for 35301. The pre-service work of 35301 is nearly identical to that of 35606 and involves review of the patient's history and physical exam, review of the carotid duplex scan, cerebral arteriogram, and head CT scan. Discussions with patient and family regarding operative indications and risks are also similar, as are preparations for surgery in the O.R. The intra-service time is similar for the two codes, but intensity for 35301 is slightly greater. Both services are quite intense, requiring careful dissection of the arterial structures of the neck with avoidance of injury to the nearby cranial nerves, but the mental effort, judgment, and technical skill of 35301 are more because a single false move during this operation can result in a devastating, permanent, stroke. The survey data supported a greater intensity for 35301 compared to 35606 with a median ratio of total intensity of the surveyed code to the reference code of 1.13.

Post-service work, on average, is slightly greater in the survey code than 35606 because patients undergoing carotid endarterectomy very frequently require administration of intravenous pressors or antihypertensives to compensate for carotid body baroreceptor malfunction induced by surgical manipulation. Overall, the survey respondents concluded that intra-service time of 35301 equals that of 35606 (median intra-time ratio = 1.00), and they concluded that the total time of the two services is equal (median total-time ratio = 1.00). The 1995 RVW for 35606 is 17.40. Thus, with a median intensity ratio of 1.13, and time ratios of 1.00, the comparison to key reference service supports a total work for 35301 of $17.40 * 1.13 * 1.00 = 19.66$.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work; time; technical skill; and physical effort; mental effort; and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research

The recommended increase in RVW for this code is based upon improvements in the accuracy of existing Harvard / RUC work, time, and intensity data for this code.

1. **Work:** The original Harvard work value for 35301 was estimated at 14.02, and this was increased to 16.13 in 1992. With introduction of a reoperation code in 1994, budget neutrality mandates resulted in a reduction in work value to the current level of 15.95. The median survey value for 35301 is 18.00, and a detailed comparison with the most frequently used reference service justifies a value of 19.66. Another estimate of work for 35301 is provided in the survey reported by the American College of Surgeons in their February 6, 1995 Comment to HCFA (Appendix VIII in that report). That survey recommended a work value of 17.81.

2. **Time:** The Harvard pre-service time is 36 minutes prior to O.R. entry, plus 1/2 of the immediate PrePost time of 61, or 31.5 minutes, for a total of 67.5 minutes. The survey median pre-service time is 90 minutes, or 33% more than the existing estimate. The Harvard intra-service time is 120 minutes, while several more recent and more accurate methods indicate the true intra-service time is essentially 140 minutes. Our median survey intra-service time was 143.5 minutes. The survey also requested that physicians report the actual time for their last 3 procedures. The median value of those data was 135 minutes. The survey also requested respondents to supply actual time data for their institutions, and the volume-weighted mean of institution's median actual intra time was 151 minutes. Finally, the SVS 10-hospital OR data analysis (Tables 1&2) documented the median time for 1,628 actual operations as 138 minutes. Considered together, these evaluations indicate that 140 minutes is a far more accurate measure of intra-service time than 120 minutes. The post-service time in the Harvard / RUC database is 140.5 minutes, while the survey post-service time is 130 minutes. Thus, pre-service time is 22.5 minutes longer and post-service time is 10.5 minutes shorter than existing data. This is almost a wash, and the major difference is work can be estimated based on the disparity in intra-service time. The survey respondents indicated that intra-work

represented 0.58 of total work for 35301 (the Harvard / RUC value is 0.54). Using the lower of these 2 values, intra-work for the 1995 RVW is 0.54×15.95 , or 8.61 units. To correct the intra-service work for a time of 140 minutes, we multiplied $140/120 \times 8.61 = 10.05$ intra-service work units. Since this represents 0.54 of total work, the new total work is $10.05 / 0.54$ or 18.61 units (the calculation comes out the same if one uses 0.58 as the percentage of intra-op service). Thus, by using more accurate intra-service time, and no adjustments for intensity, the RVW calculates to 18.61.

3. **Intensity:** The intensity of 35301 is the highest of all codes in our survey, including the key reference codes and those undergoing investigation, with a median mental effort value of 4, median technical skill value of 4, and median psychological stress value of 5. No other service scored a 5 for psychological stress, and no other service had a sum of 13 for these 3 parameters. These intensity values represent the fact that a single false move during this operation may result in a devastating stroke. While intensity is difficult to quantify, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. The IWPUT for 35301 in 1995 is 0.070 based on our SVS 10-hospital OR data analysis and 0.071 according to the "Summary of Work and Time Estimates for Services Undergoing Investigation (AMA RUC 6/8/95). This is less than that for TURP (0.120), Cataract removal (0.110), total knee arthroplasty (0.084), and several other common services (Table 1). If 35301 is recalculated using just the median IWPUT from the SVS study (0.082), a more accurate reflection of intra-service intensity is reached. By this technique, intra-work is $140 \times 0.082 = 11.48$ units. Since intra-work represents 0.58 of total work, the total work is $11.48 / 0.58 = 19.73$ RVUs (see Appendix for an expansion of this argument). Thus, by adjusting the intensity of intra-service work to a more reasonable level, 35301 merits a work value of 19.79.

4. **Summary** Five different analyses suggest work values from 17.81 to 19.79 for this service:

1. Median survey value is 18.
2. Comparison to reference code 35606 suggests a work value of 19.66.
3. The American College of Surgeons survey suggested 17.81.
4. A relative time analysis computes a work value of 18.61.
5. The IWPUT method justified an RVW of 19.79.

Our original letter of comment recommended an RVW for 35301 of 18.76 units. After careful review of the survey instrument and 4 supplemental work analyses for 35301, we recommend an RVW of 18.

APPENDIX: IWPUT Method for work calculation of 35301

1. Intra-service work per unit time (IWPUT) ranges from 0.05 to 0.12 for virtually all surgical services.
2. Intra-service work per unit time (IWPUT) ranged from 0.050 to 0.120 in the SVS Operative Log Data Analysis presented in Table 1.
3. The median IWPUT for the 12 non-vascular operations in Table 1 was 0.082.
4. The performance of 35301 with its attendant stroke risk should merit at least the median level of intra-service work per unit time. The survey intensity ratings would actually support more than a median IWPUT level.
5. The intra-service time for 35301 is well-established at 140 minutes.
6. The intra-service work for 35301 should equal the operative time multiplied by the median surgical IWPUT, or $140 \times 0.082 = 11.48$
7. The pre and post-service work for 35301 are at least typical of the average operation of that magnitude, in that patients presenting for this operation commonly suffer from symptomatic coronary artery disease, hypertension, diabetes, hyperlipidemia, and COPD. In addition, post-operative management often includes the requirement for intravenous pressors or antihypertensives.
8. The RUC survey data indicates that intra-service work represents 0.58 of total work. In other words, $\text{total work} = \text{intra-work} / 0.58$.
9. The total work of 35301, based on a median IWPUT value, should be $11.48 / 0.58 = 19.79$

Public Comments

30-Jun-95

Code: 35301

1995 RVUs: 15.95

Recommended RVUs: 18.76

Ratio:

Long Descriptor: Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision

Reference Set (y/n): Y Global Period: 090 Frequency: 69,700 Impact: 195857

Source: 2 Year: 92 Public Comment Letter: 185

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SVS

Societies Wishing to Comment: ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
35301	45.6	5.5	4.2	42.8	4.5	0.1	0.5	10.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
35301	68255	71538	2.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
35301	98.2	98.8	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
35301	cardiac surgery	7.1
	cardiovascular disease	2.4
	general surgery	35.1
	group practices	2.6
	neurological surgery	5.8
	thoracic surgery	22
	vascular surgery	22.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
35301			

Public Comments

30-Jun-95

433	22.6	OCCLUSION AND STENOSIS OF PRECERE
435	2.1	TRANSIENT CEREBRAL ISCHEMIA

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
35301							
ASGS		090	090	14.02	15.95	1.14	16.19
SVS		090	090	14.02	15.95	1.14	16.19

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
35301								
ASGS	16.19	15.95	1.15	1.00	0.99	1.00	18.76	185
SVS	16.19	15.95	1.15	1.00	0.99	1.00	17.41	337

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
35301								
ASGS	090	14.02		36		120		61
SVS	090	14.02		36		120		61

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
35301									
ASGS		1.5		10	5.0		10	1.0	2.0
SVS		1.5		10	5.0		10	1.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
35301									
ASGS		15		18.76	15.95	xx	n		0.071
SVS		15		17.41	15.95	xx	n		0.071

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 35556 **Global Period:** 090 **1995 RVW:** 15.47 **Recommended RVW:** 22.00

CPT Descriptor: Bypass graft, with vein; femoral-popliteal

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 11 vascular surgeons designed a study to measure the major component of work for vascular surgical procedures by collecting and analyzing accurate intraoperative surgery time (skin-to-skin) of commonly performed vascular and non-vascular procedures. Data were collected from operative logs and computer databases at ten hospitals, both private and University. Median intra-Service time and intra-service work per minute (IWPUT) were calculated (Table 1). The results of this study found the intra-service work of code 35556 to be significantly undervalued based on a comparison with typical "signature" procedures from many other surgical disciplines. These intra-service work comparisons formed the basis for choosing procedures to be surveyed for all aspects of work in the five-year review.

1994 Frequency of Service: 10,168

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78 year old male with a 63 pack-year history of smoking presents with a history of a non healing ulcer over his left first metatarsal. He has long standing hypertension, recent diabetes controlled with oral medication, and mild angina on occasion. He has had a previous coronary artery bypass eleven years before, and the right saphenous vein was used. He has worsening pain in his foot at rest. Arteriography, as an out-patient, revealed an occlusion of his superficial femoral artery and reconstitution of the popliteal artery at the knee with a mildly diseased posterior tibial artery and an open peroneal artery as run-off. The anterior tibial artery is occluded throughout. Cardiac evaluation is done as an out-patient. He is admitted to the hospital; appropriate invasive monitoring is done, an epidural catheter is inserted for anesthesia, and a femoral-popliteal bypass using reversed saphenous vein is constructed below the knee. Postoperatively he spends one day in the ICU, and is able to be discharged from the hospital on the tenth postoperative day with a warm pain free foot.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before the operation until the beginning of the procedure. This includes obtaining and reviewing pre-procedural work-up, with special attention to cardiopulmonary and hematologic status; reviewing previous imaging studies (especially arteriograms) and laboratory studies; consulting with the referring physician and cardiologist, if necessary, and other health care professionals; and communicating with the patient and patient's family to review the operative risks, benefits, and alternative treatments, and to obtain informed consent. Other pre-operative services include dressing, being present while appropriate invasive monitoring is done with insertion of a Swan-Ganz catheter (if necessary), arterial line, and Foley catheter. Sequential compression devices (on the contralateral leg if desired by the surgeon) are applied and placement of non-invasive ECG and oxygen saturation monitoring devices, and satisfactory anesthesia, generally consisting of insertion of an epidural catheter (or establishing general anesthesia via endotracheal inhalation), is achieved. Additional pre-operative services include ensuring that sufficient blood, especially if the patient has previously donated blood, is available, that the surgical instruments and

supplies that might be necessary are available in the operative suite, scrubbing and supervision of the positioning, prepping, and draping of the patient. Appropriate lines are connected including electrocautery and suction tubes.

Description of Intra-Service work: An incision is made in the groin and the common femoral, superficial femoral, and profunda femoris arteries as well as the greater saphenous vein are isolated and encircled. The incision is then extended down the thigh and lower leg over the greater saphenous vein until sufficient vein is exposed to allow the bypass to be constructed, using one continuous segment of vein for the bypass. This usually requires an incision from the groin to mid-calf. The point for the distal anastomosis to the popliteal artery (almost always below the knee) is identified, and the medial incision below the knee is extended down to the popliteal artery. The branches of the vein are carefully dissected and ligated with meticulous attention to making sure the saphenous vein wall itself is not damaged. Measures to protect the vein endothelium are used and the distal end of the vein is then anastomosed to the femoral artery in an end-of-vein to side-of-artery fashion. The vein conduit is flushed with arterial flow to make sure the rate of flow is sufficient and any small bleeding points are carefully closed with fine sutures. The vein is then tunneled to the point of the distal anastomosis and an anastomosis is made between the vein and the popliteal artery. Once satisfactory flow into the distal arterial circulation is determined, the incision from the groin to mid-calf is carefully closed in layers.

Description of Post-Service work: Post-service work begins after skin closure in the operating room and includes application of sterile bandages, checking the extremity for adequate arterial perfusion, and transfer of the patient to the recovery room where postoperative orders are written. Post-service work also includes stabilization of the patient in the recovery room, monitoring blood gas values as well as obtaining electrolytes and a hematocrit. It also includes communication with the family and other health care professionals (including written and oral reports and orders), all hospital visits and services performed by the surgeon, including ICU care and ventilator management as necessary, careful monitoring of cardiopulmonary, and hemodynamic status; ordering and reviewing post-operative radiographs and laboratory studies; monitoring and care of the incision which has a high incidence of incision edge necrosis; monitoring care, most especially physical therapy for training in ambulation, and removal of all tubes and drains; and antibiotics and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital and likely post hospital events, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure including removal of sutures, out-patient wound care, evaluation of periodic imaging and laboratory reports, and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: Society for Vascular Surgery (SVS) / International Society for Cardiovascular Surgery (ISCVS)

Sample Size: 58 **Response Rate:** 40 (69%) **Median RVW:** 22

25th percentile RVW: 18.85 **75th Percentile RVW:** 24 **Low:** 12.28 **High:** 40

Median Pre-Service Time: 90 **Median Intra-Service Time:** 200

25th Percentile Intra-Svc Time: 180 **75th Percentile Intra-Svc Time:** 240 **Low:** 100 **High:** 306

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	40	
ICU:	30	2
Other Hospital:	107.5	9
Office:	45	3

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 35606	Bypass Graft, with other than vein, carotid-subclavian	17.40
2) 35372	Thromboendarterectomy, with or without patch graft; deep (profunda) femoral	12.28
3) 43631	Gastrectomy, partial, distal; with gastroduodenostomy	18.10
4) 47130	Hepatectomy, resection of liver; total right lobectomy	31.56

RELATIONSHIP OF CODE UNDER SURVEY TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Construction of a reference service table (Table 3) for the 5-year reevaluation was difficult for the vascular codes since most of the vascular procedures on the MPC list were submitted for reevaluation. The SVS/ISCVS advisors asked the RUC administrative staff for assistance with construction of the reference service table; we were referred to Dr. Kwass, chair of the RUC research subcommittee to which these codes are assigned. The recommendation was to choose some vascular codes if, in our opinion they were approximately correctly valued, as well as some reference services from the general surgery codes on the

MPC list since 1) all vascular surgeons have completed a full 5 year categorical general surgery residency and are therefore familiar with general surgery cases and 2) while we are "vascular surgeons" by dint of concentrated training or fellowship programs in vascular surgery, many vascular surgeons have practices which include general surgery cases in addition to their vascular practice. Thus, while the reference services are related to the code being surveyed by pre-service work, operative time, intensity, and magnitude of the operation, in addition to post-service work and global periods, the actual operations may be dissimilar.

Comparison to 35606: The survey respondents believed that the intra-service time spent for 35556 was 1.33 times greater than that of 35606, the total time was 1.44 times that of 35606, and the intensity was equivalent to that of 35606.¹ The calculated total work ratio was 1.46 times greater than 35606.² Applying this ratio to the current value (17.40 RVWs) of 35606, yields a work value of **25.40 RVWs** (17.40 x 1.46) for 35556. This result compares favorably with the recommended RVW of 22.00. Additional time and intensity data for 35606 from the Summary of Work and Time Estimates for Services Undergoing Investigation (AMA/RUC 6/8/95) were not available for analysis.

Comparison to E/M codes: The work of 35556 may be calculated as the sum of the following E/M services, using intensive care codes as the best comparison to the complex intra-service work involved in this service:

<u>Service</u>	<u>Time</u>	<u>E/M Code</u>	<u>RVW</u>
Pre-Service	90	99215	1.51
Intra-service	200	99291 + 99292 x 5	12.84
Post-day of proc	40	99291	3.64
POD #1 ICU	30	99291	3.64
POD #2-9	10	99231 x 8	4.08
POD #10 Disch	35	99238	1.06
Office x 3	45	99213 x 3	1.65
Total			28.42

Thus, by using the E/M reference service building-block method, the work of 35556 should be **28.42 units**, which further justifies an RVW of 22.

¹For each respondent who listed the given reference service for the given survey code, the ratios of intra-service time, total time, and total intensity of the survey procedure to the reference procedure were calculated. The ratios shown represent the medians of the ratios calculated across those observations.

²For each respondent who listed the given reference service for the given survey code, the ratio of total time to total intensity was calculated. The ratio shown represents the median of the ratios calculated across those observations.

RATIONALE:

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The recommended increase in RVW is based upon improvements in the accuracy of existing Harvard work and time data for this code.

1. Work: The work value originally assigned was 17.05 units. It now has a value of 15.47. The current survey suggests that the work value should be 22 work units (median value). This value is easily justified by comparison to the key reference service which suggests a value of 25.40 units, and by the the E/M building block calculation of 28.42 units. In addition, the work survey reported by the American College of Surgeons in their February 6, 1995 Comment to HCFA suggests a comparable work value of 21.62 units.

2. Time: The Harvard intra-service time is 156 minutes, while several more recent and more accurate methods indicate that the true intra-service time is considerably longer. Our median survey intra-service time was 200 minutes. The survey also requested that physicians report the actual times for their last three procedures. The median value for those procedures was 205 minutes. The survey also requested respondents to supply actual time data from their hospitals, and the volume weighted mean of these institution's median times was 224 minutes. Finally, the SVS 10 hospital OR data analysis (Table 1) revealed that the median time was 252 minutes. Considered together, these data suggest that 200 minutes is a conservative estimate of the median time and is a far more accurate measure of intra-service time than 156 minutes. Likewise, the Harvard data give a figure of 69.5 minutes for pre-service time, whereas the median survey pre-service time was 90 minutes. The Harvard post-service time was 162.5 minutes, whereas the survey time was 222.5 minutes. The Harvard survey did not include an ICU day. An ICU day is common after a limb salvage operation in a patient with many comorbidities who is likely to have an arterial line and an epidural catheter in place (only 2 of our 38 respondents felt that our vignette was atypical).

3. Intensity: The intensity of 35556 is high with a median mental effort/judgment of 4, a median technical skill value of 4, and median psychological stress value of 3. While intensity is difficult to compute back to work values, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. The IWPUT for 35556 in 1995 is 0.026 based on our SVS 10 hospital data analysis of OR log times for procedures (Table 1). It is 0.064 according to the Summary of Work and Time Estimates for Services Undergoing Investigation (AMA/RUC 6/8/95). This is less than that accorded most other major procedures in all other specialties. If 35556 is recalculated using an IWPUT of 0.07 (the low end of the spectrum of major complicated and at least moderately intense procedures), a more accurate reflection of intra-service intensity is achieved. By this technique, intra-work is $200 \times 0.07 = 14.00$ units. Since intra-work represents 0.44 of total work based on the current survey, the total work is $14.00/0.44 = 31.81$ units (see attached Appendix for an expanded discussion). Thus, by adjusting the intensity of intra-service work to a more reasonable level, 35556 has a work value of 31.82 units.

4. Summary: Five different analyses suggest work values from 22.00 to 31.82 for this service:

1. Median survey value is **22.00**.
2. Comparison to 35606, the most frequently used reference service by our survey respondents, suggests a value of **25.40**.
3. The E/M building block method resulted in an estimate of **28.42**.
4. The American College of Surgeons survey suggested **21.62**.
5. Using the most conservative IWPUT figures, this analysis technique suggests a value of **31.82**.

After careful review of the survey results and supplemental work analyses for 35556, we recommend an RVW of 22.00.

Appendix: IWPUT Method for work calculation of 35556

1. Intra-service work per unit time (IWPUT) ranges from 0.05 to 0.12 for virtually all surgical services.
2. Intra-service work per unit time (IWPUT) ranged from 0.026 to 0.12 in the SVS Operative Log Data analysis presented in Table 1.
3. The median IWPUT for the 12 non-vascular operations in Table 1 was 0.082. Almost all major operations with reasonably high level of intensity will have an IWPUT of at least 0.070. Almost all major vascular procedures have an IWPUT of less than 0.070.
4. The performance of 35556 with its attendant risks of cardiac complications, failure, and possible limb loss should merit at least the low end of the usual spectrum of major complicated and at least moderately intense procedures. (The survey intensity ratings would actually support more than a low-end IWPUT level.)
5. The Survey intra-service median time for 35556 of 200 minutes is substantiated by our original OR log data analysis (252 min).
6. The intra-service work for 35556 should equal the operative time multiplied by the low end major surgical IWPUT, or $200 \times 0.070 = 14$.
7. The pre- and post- service work for 35556 are at least typical of the average operation of large magnitude in that patients presenting for this operation commonly suffer from symptomatic coronary disease, hypertension, diabetes, hyperlipidemia, obesity and COPD.
8. The RUC survey data indicate that intra-service work represents 0.44 of total work. In other words $\text{total work} = \text{intra-work} / 0.44$.
9. The total work of 35556, based on a low end of the spectrum (0.070) IWPUT value, should be $14 / 0.44 = 31.81$.

Public Comments

30-Jun-95

Code: 35556

1995 RVUs: 15.47

Recommended RVUs: 23.18

Ratio:

Long Descriptor: Bypass graft, with vein; femoral-popliteal

Reference Set (y/n): Y

Global Period: 090

Frequency: 9,138

Impact: 70454

Source: 2

Year: 92

Public Comment Letter: 185

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SVS

Societies Wishing to Comment: ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
35556	44.2	7.8	14.1	42.4	8.7	0.4	6.5	10.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
35556	10983	10168	-3.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
35556	98.3	99.1	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
35556	cardiac surgery	4.1
	cardiovascular disease	2
	general surgery	43.7
	group practices	2.8
	thoracic surgery	20.5
	vascular surgery	24.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
35556	250	1.5	DIABETES MELLITUS

Public Comments

30-Jun-95

440	6.5	ATHEROSCLEROSIS
442	1.5	OTHER ANEURYSM
443	7.3	OTHER PERIPHERAL VASCULAR DISEAS
444	8	ARTERIAL EMBOLISM AND THROMBOSI
459	1.6	OTHER DISORDERS OF CIRCULATORY S
707	1.4	CHRONIC ULCER OF SKIN
785	2.3	SYMPTOMS INVOLVING CARDIOVASCUL

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
35556							
ASGS		090	090	17.05	15.47	0.91	16.04
SVS		090	090	17.05	15.47	0.91	16.04

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
35556								
ASGS	16.04	15.47	0.94	1.00	0.96	1.00	23.18	185
SVS	16.04	15.47	0.94	1.00	0.96	1.00	22.30	337

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
35556								
ASGS	090	17.05		37		156		65
SVS	090	17.05		37		156		65

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
35556									
ASGS		1.0		10	8.5		10	0.0	3.5
SVS		1.0		10	8.5		10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
35556									
ASGS		10		23.18	15.47	gs	3		0.064
SVS		10		22.30	15.47	gs	3		0.064

by dint of concentrated training or fellowship programs in vascular surgery, many vascular surgeons have practices which include general surgery cases in addition to their vascular practice. Thus, while the reference services are related to the code being surveyed by pre-service work, operative time, intensity, and magnitude of the operation, in addition to post-service work and global periods, the actual operations may be dissimilar.

Comparison to 35606: The survey respondents believed that the intra-service time spent for 35566 was 1.64 times greater than the intra-service time of 35606, the total time was 1.62 times greater than that for 35606, and the intensity was 1.17 times that of 35606. The calculated total work ratio was 1.96 times that of 35606. Applying the ratio of 1.96 to 17.40 results in a work value of **34.10 RVWs** (1.96×17.40) for 35566. This comparison, therefore, suggests that a work value of **26.25 RVW** for 35566 is quite reasonable, using 35606 as a reference code. Additional time and intensity data for 35372 from the Summary of Work and Time Estimates for Services Undergoing Investigation (AMA/RUC 6/8/95) were not available for analysis.

Comparison to E/M Codes: The work of 35566 may be calculated as the sum of the following E/M services, using intensive care codes as the best comparison to the complex intra-service work involved in this service:

<u>Service</u>	<u>Time</u>	<u>E/M Code</u>	<u>RVW</u>
Pre-Service	90	99215	1.51
Intra-service	258	99291 + 99292 x 7	16.52
Post-day of proc	40	99291	3.64
POD #1 ICU	30	99291	3.64
POD #2-9	10	99231 x 8	4.08
POD #10 Disch	35	99238	1.06
Office x 3	45	99213 x 3	1.65
Total			32.10

Thus, by using the E/M reference service building-block method, the work of 35566 should be 32.10 units, further justifying an RVW of 26.25.

RATIONALE:

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The recommended increase in RVW is based upon improvements in the accuracy of existing Harvard work, time, and intensity data for this code.

1. Work: The original Harvard work value assigned to 35566 was 18.65 units. This value was determined by a panel without substantial participation by vascular surgeons (see Introduction). The RVU was decreased to 15.47 in 1992 and increased to 20.21 in 1994. The median RVW of the current survey is 26.25 units. When comparing 35566 to the most frequently used reference service, CPT 35606, a work value of 34.10 is computed, providing additional evidence for an increase in the work units for this service. The E/M building block calculation of 32.10 units also compares favorably with the requested RVW of 26.25. Furthermore, the work survey reported by the American College of Surgeons in their February 6, 1995 Comment to HCFA (Appendix VIII in that report) suggests a work value of 26.54.

2. Time: The Harvard intra-service time is 218 minutes, while several more recent and more accurate methods indicate that the true intra-service time is considerably longer. Our median survey intra-service time was 258 minutes. The survey also requested that physicians report the actual times for their last three procedures. The median value for those procedures was 254 minutes. The survey also requested respondents to supply actual time data from their hospitals, and the volume weighted mean of these institution's median times was 265 minutes. Finally, the SVS 10 hospital OR data analysis (Table 1) revealed that the median time was 341 minutes. Considered together, these data suggest that 258 minutes is a more accurate measure of intra-service time than the 218 minutes indicated by the Harvard data. Likewise, the Harvard data give a figure of 68.5 minutes for pre-service time, whereas the median survey pre-service time was 90 minutes. In addition, the Harvard post-service time was 162.5 minutes, whereas the survey post-service time was 230 minutes. The Harvard survey did not include an ICU day; however, an ICU day is common after a limb salvage operation in a patient with many comorbidities who is likely to have an arterial line and an epidural catheter in place (none of our respondents felt that our vignette was atypical).

3. Intensity: The intensity of 35566 is very high with a median mental effort/judgment of 4, a median technical skill value of 4 and median psychological stress value of 4. While intensity is difficult to compute back to work values, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. The IWPUT for 35566 in 1995 is 0.038 based on our SVS 10 hospital data analysis of OR log times for procedures (Table 1). It is 0.056 according to the Summary of work and time estimates for services undergoing investigation (AMA/RUC 6/8/95). This is considerably less than that accorded most other major procedures in all other specialties. If 35566 is recalculated using an IWPUT of 0.07 (the low end of the spectrum of major complicated and at least moderately intense procedures), a more accurate reflection of intra-service time is achieved. By this technique, intra-work is $258 \times 0.07 = 18.06$ units. Since intra-work is 50% of the total work based on the survey data, the total work is $18.06/0.50 = 36.12$ units (see attached Appendix for an expanded discussion). Thus, this method of deriving work strongly supports the survey request of 26.25 units.

4. Summary: Five different analyses suggest work values from 26.25 to 36.12 for this service:

1. Median survey value is **26.25**.
2. Comparison to reference code 35606 suggests a work value of **34.10**.
3. The E/M building block method results in an estimate of **32.10**.

4. The American College of Surgeons survey suggested 26.54.
5. The IWPUT method, using conservative IWPUT figures, justified a value of 36.12.

After careful consideration of the survey results and supplemental work analyses for 35566, we recommend an RVW of 26.25.

Appendix: IWPUT Method for work calculation of 35566

1. Intra-service work per unit time (IWPUT) ranges from 0.05 to 0.12 for virtually all surgical services.
2. Intra-service work per unit time (IWPUT) ranged from 0.026 to 0.12 in the SVS Operative Log Data analysis presented in Table 1.
3. The median IWPUT for the 12 non-vascular operations in Table 1 was 0.082. Almost all major operations with reasonably high level of intensity will have an IWPUT of at least 0.070. Almost all major vascular procedures have an IWPUT of less than 0.070.
4. The performance of 35566 with its attendant risks of cardiac complications, failure, and possible limb loss should merit at least the low end of the usual spectrum of major complicated and at least moderately intense procedures. (The survey intensity ratings would actually support more than a low-end IWPUT level.)
5. The Survey intra-service median time for 35566 of 258 minutes is substantiated by our original OR log data analysis (341 min). In fact, these data would suggest that 258 is a conservative (low) number.
6. The intra-service work for 35566 should at least equal the operative time multiplied by the low end major surgical IWPUT, or $258 \times 0.070 = 18.06$.
7. The pre- and post- service work for 35566 are at least typical of the average operation of large magnitude in that patients presenting for this operation commonly suffer from symptomatic coronary disease, hypertension, diabetes, hyperlipidemia, obesity and COPD.
8. The RUC survey data indicate that intra-service work represents 0.50 of total work. In other words total work = intra-work / 0.50.
9. The total work of 35566, based on a low end of the spectrum (0.070) IWPUT value, should be $18.06 / 0.50 = 36.12$.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 35566 **Global Period:** 090 **1995 RVW:** 20.21 **Recommended RVW:** 26.25

CPT Descriptor: Bypass graft, with vein, femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 11 vascular surgeons designed a study to measure the major component of work for vascular surgical procedures by collecting and analyzing accurate intraoperative surgery time (skin-to-skin) of commonly performed vascular and non-vascular procedures. Data were collected from operative logs and computer databases at ten hospitals, both private and University. Median intra-service time and intra-service work per minute (IWPUT) were calculated (Table 1). The results of this study found the intra-service work of code 35566 to be significantly undervalued based on a comparison with typical "signature" procedures from many other surgical disciplines. These intra-service work comparisons formed the basis for choosing procedures to be surveyed for all aspects of work in the five-year review.

1994 Frequency of Service: 8,893

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78 year old male with a 63 pack-year history of smoking presents with a history of a non healing ulcer over his left first metatarsal. He has long standing hypertension, recent diabetes controlled with oral medication, and mild angina on occasion. He has had a previous coronary artery bypass eleven years before, and the right saphenous vein was used. He has worsening pain in his foot at rest. Arteriography, as an out-patient, revealed an occlusion of his superficial femoral artery and reconstitution of the posterior tibial artery at the level of his medial malleolus. His anterior tibial artery and his peroneal artery were not acceptable out-flow conduits. Cardiac evaluation is done as an out-patient. He is admitted to the hospital; appropriate invasive monitoring is done, an epidural catheter is inserted for anesthesia, and a femoral-posterior tibial bypass using reversed saphenous vein is constructed. Postoperatively he spends one day in the ICU, and is able to be discharged from the hospital on the tenth postoperative day with a palpable posterior pulse.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before the operation until the beginning of the procedure. This includes obtaining and reviewing pre-procedural work-up, with special attention to cardiopulmonary and hematologic status; reviewing previous imaging studies (especially arteriograms) and laboratory studies; consulting with the referring physician and cardiologist, if necessary, and other health care professionals; and communicating with the patient and patient's family to review the operative risks, benefits, and alternative treatments, and to obtain informed consent. Other pre-operative services include dressing, being present while appropriate invasive monitoring is done with insertion of a Swan-Ganz catheter (if necessary), arterial line, and Foley catheter. Sequential compression devices (on the contralateral leg if desired by the surgeon) are applied and placement of non-invasive ECG and oxygen saturation monitoring devices, and satisfactory anesthesia, generally consisting of insertion of an epidural catheter (or establishing general anesthesia via endotracheal inhalation), is achieved. Additional pre-operative services include ensuring that sufficient blood,

especially if the patient has previously donated blood, is available, that the surgical instruments and supplies that might be necessary are available in the operative suite, scrubbing and supervision of the positioning, prepping, and draping of the patient. Appropriate lines are connected including electrocautery and suction tubes.

Description of Intra-Service work: An incision is made in the groin and the common femoral, superficial femoral, and profunda femoris arteries as well as the greater saphenous vein are isolated and encircled. The incision is then extended down the thigh and lower leg over the greater saphenous vein until sufficient vein is exposed to allow the bypass to be constructed using one continuous segment of vein for the bypass. This usually requires an incision from the groin to near the ankle. The point for the distal anastomosis is identified, an incision is made, and the distal artery is exposed. The vein is carefully dissected free with meticulous attention to making sure the vein wall is not damaged. Measures to protect the vein endothelium are used and the distal end of the vein is then anastomosed to the femoral artery in an end-of-vein to side-of-artery fashion. The vein conduit is flushed with arterial flow to make sure the rate of flow is sufficient and any small bleeding points are carefully closed with fine sutures. The vein is then tunneled to the point of the distal anastomosis and an anastomosis, using magnification, is made between the vein and the distal artery. Once satisfactory flow into the distal arterial circulation is determined, the incision from the groin to near the ankle is carefully closed in layers.

Description of Post-Service work: Post-service work begins after skin closure in the operating room and includes application of sterile bandages, checking the extremity for adequate arterial perfusion, and transfer of the patient to the recovery room where postoperative orders are written. Post-service work also includes stabilization of the patient in the recovery room, monitoring blood gas values as well as obtaining electrolytes and a hematocrit. It also includes communication with the family and other health care professionals (including written and oral reports and orders), all hospital visits and services performed by the surgeon, including ICU care and ventilator management as necessary, careful monitoring of cardiopulmonary, and hemodynamic status; ordering and reviewing post-operative radiographs and laboratory studies; monitoring and care of the incision which has a high incidence of incision edge necrosis; monitoring care, most especially physical therapy for training in ambulation, and removal of all tubes and drains; and antibiotics and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital and likely post hospital events, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure including removal of sutures, out-patient wound care, evaluation of periodic imaging and laboratory reports, and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: Society for Vascular Surgery (SVS) / International Society for Cardiovascular Surgery (ISCVS)

Sample Size: 58 **Response Rate:** 40 (69%) **Median RVW:** 26.25

25th percentile RVW: 22.5 **75th Percentile RVW:** 30 **Low:** 16 **High:** 45

Median Pre-Service Time: 90 **Median Intra-Service Time:** 258

25th Percentile Intra-Svc Time: 220 **75th Percentile Intra-Svc Time:** 300 **Low:** 120 **High:** 420

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	40	
ICU:	30	2
Other Hospital:	115	9
Office:	45	3

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1995 RVW</u>
1)	35606	Bypass Graft, with other than vein, carotid-subclavian	17.40
2)	47130	Hepatectomy, resection of liver; total right lobectomy	31.56
3)	35372	Thromboendarterectomy, with or without patch graft; deep (profunda) femoral	12.28
4)	43631	Gastrectomy, partial, distal; with gastroduodenostomy	18.10

RELATIONSHIP OF CODE UNDER SURVEY TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Construction of a reference service table (Table 3) for the 5-year reevaluation was difficult for the vascular codes since most of the vascular procedures on the MPC list were submitted for reevaluation. The SVS/ISCVS advisors asked the RUC administrative staff for assistance with construction of the reference service table; we were referred to Dr. Kwass, chair of the RUC research subcommittee to which these codes are assigned. The recommendation was to choose some vascular codes if, in our opinion they were approximately correctly valued, as well as some reference services from the general surgery codes on the MPC list since 1) all vascular surgeons have completed a full 5 year categorical general surgery residency and are therefore familiar with general surgery cases and 2) while we are "vascular surgeons"

Public Comments

30-Jun-95

Code: 35566**1995 RVUs:** 20.21**Recommended RVUs:** 29.06**Ratio:****Long Descriptor:** Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels**Reference Set (y/n):** N **Global Period:** 090 **Frequency:** 7,948 **Impact:** 70340**Source:** 5 **Year:** 93 **Public Comment Letter:** 337**Reference Services:****CMD Comment:**

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Societies Wishing to Survey: SVS**Societies Wishing to Comment:** ACS**Trends Analysis – Beneficiary Information:**

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
35566	53.2	11.2	20.9	39.1	6	2.6	6	5.5

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
35566	7323	8893	10.2

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
35566	98	99.2	0.6

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
35566	cardiac surgery	2.5
	general surgery	37.9
	group practices	4.4
	thoracic surgery	16.6
	vascular surgery	34.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
35566	250	1.7	DIABETES MELLITUS
	440	6.3	ATHEROSCLEROSIS

Public Comments

30-Jun-95

443	5.3	OTHER PERIPHERAL VASCULAR DISEAS
444	8.9	ARTERIAL EMBOLISM AND THROMBOSI
459	2.5	OTHER DISORDERS OF CIRCULATORY S
707	1.7	CHRONIC ULCER OF SKIN
785	5	SYMPTOMS INVOLVING CARDIOVASCUL
996	1.6	COMPLICATIONS PECULIAR TO CERTAI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
35566							
SVS		090	090	18.65	20.21	1.08	15.47

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
35566								
SVS	20.88	20.21	0.83	1.35	0.97	1.00	29.06	337

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
35566								
SVS	090	18.65		36		218		65

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
35566									
SVS		1.0		10	8.5		10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
35566									
SVS		10		29.06	20.21	gs	3		0.056

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 35583 **Global Period:** 090 **1995 RVW:** 15.97 **Recommended RVW:** 24.00

CPT Descriptor: In-situ vein bypass; femoral-popliteal

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 11 vascular surgeons designed a study to measure the major component of work for vascular surgical procedures by collecting and analyzing accurate intraoperative surgery time (skin-to-skin) of commonly performed vascular and non-vascular procedures. Data were collected from operative logs and computer databases at ten hospitals, both private and University. Median intra-Service time and intra-service work per minute (IWPUT) were calculated (Table 1). The results of this study found the intra-service work of code 35583 to be significantly undervalued based on a comparison with typical "signature" procedures from many other surgical disciplines. These intra-service work comparisons formed the basis for choosing procedures to be surveyed for all aspects of work in the five-year review.

1994 Frequency of Service: 4,864

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78 year old male with a 63 pack-year history of smoking presents with a history of a non healing ulcer over his left first metatarsal. He has long standing hypertension, recent diabetes controlled with oral medication, and mild angina on occasion. He has had a previous coronary artery bypass eleven years before, and the right saphenous vein was used. He has worsening pain in his foot at rest. Arteriography, as an out-patient, revealed an occlusion of his superficial femoral artery and reconstitution of the popliteal artery at the knee with a mildly diseased posterior tibial artery and an open peroneal artery as run-off. The anterior tibial artery is occluded throughout. Cardiac evaluation is done as an out-patient. He is admitted to the hospital; appropriate invasive monitoring is done, an epidural catheter is inserted for anesthesia, and a femoral-popliteal bypass using in-situ saphenous vein is constructed below the knee. Postoperatively he spends one day in the ICU, and is able to be discharged from the hospital on the tenth postoperative day with a warm pain free foot.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before the operation until the beginning of the procedure. This includes obtaining and reviewing pre-procedural work-up, with special attention to cardiopulmonary and hematologic status; reviewing previous imaging studies (especially arteriograms) and laboratory studies; consulting with the referring physician and cardiologist, if necessary, and other health care professionals; and communicating with the patient and patient's family to review the operative risks, benefits, and alternative treatments, and to obtain informed consent. Other pre-operative services include dressing, being present while appropriate invasive monitoring is done with insertion of a Swan-Ganz catheter (if necessary), arterial line, and Foley catheter. Sequential compression devices (on the contralateral leg if desired by the surgeon) are applied and placement of non-invasive ECG and oxygen saturation monitoring devices, and satisfactory anesthesia, generally consisting of insertion of an epidural catheter (or establishing general anesthesia via endotracheal inhalation), is achieved. Additional pre-operative services include ensuring that sufficient blood, especially if the patient has previously donated blood, is available, that the surgical instruments and supplies that might be necessary are available in the operative suite, scrubbing and supervision of the

positioning, prepping, and draping of the patient. Appropriate lines are connected including electrocautery and suction tubes.

Description of Intra-Service work: An incision is made in the groin and the common femoral, superficial femoral, and profunda femoris arteries as well as the greater saphenous vein are isolated and encircled. The incision is then extended down the thigh and lower leg over the greater saphenous vein until sufficient vein is exposed to allow the bypass to be constructed using one continuous segment of vein for the bypass. This usually requires an incision from the groin to mid-calf. The point for the distal anastomosis (almost always below the knee) is identified, and the medial incision below the knee is extended down to the popliteal artery. The branches of the vein are carefully dissected and ligated with meticulous attention to making sure the saphenous vein wall itself is not damaged. The proximal end of the vein is then anastomosed to the femoral artery in an end-of-vein to side-of-artery fashion. The distal vein is divided and mobilized sufficiently to allow an anastomosis of the distal vein to the popliteal artery. The vein valves are then disrupted mechanically and the vein conduit is flushed with arterial flow to make sure the rate of flow is sufficient and any small bleeding points are carefully closed with fine sutures. An anastomosis is then made between the vein and the popliteal artery. Once satisfactory flow into the distal arterial circulation is determined, the incision from the groin to mid-calf is carefully closed in layers.

Description of Post-Service work: Post-service work begins after skin closure in the operating room and includes application of sterile bandages, checking the extremity for adequate arterial perfusion, and transfer of the patient to the recovery room where postoperative orders are written. Post-service work also includes stabilization of the patient in the recovery room, monitoring blood gas values as well as obtaining electrolytes and a hematocrit. It also includes communication with the family and other health care professionals (including written and oral reports and orders), all hospital visits and services performed by the surgeon, including ICU care and ventilator management as necessary, careful monitoring of cardiopulmonary, and hemodynamic status; ordering and reviewing post-operative radiographs and laboratory studies; monitoring and care of the incision which has a high incidence of incision edge necrosis; monitoring care, most especially physical therapy for training in ambulation, and removal of all tubes and drains; and antibiotics and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital and likely post hospital events, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure including removal of sutures, out-patient wound care, evaluation of periodic imaging and laboratory reports, and antibiotic and pain medication adjustments.

SURVEY DATA:**Specialty:** Society for Vascular Surgery (SVS) / International Society for Cardiovascular Surgery (ISCVS)**Sample Size:** 58 **Response Rate:** 35 (60.3%) **Median RVW:** 24**25th percentile RVW:** 20 **75th Percentile RVW:** 26.5 **Low:** 15 **High:** 50**Median Pre-Service Time:** 90 **Median Intra-Service Time:** 220**25th Percentile Intra-Svc Time:** 180 **75th Percentile Intra-Svc Time:** 241 **Low:** 120 **High:** 407

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	40	
ICU:	30	2
Other Hospital:	90	9
Office:	40	2.5

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1995 RVW</u>
1) 35606	Bypass Graft, with other than vein, carotid-subclavian	17.40
2) 35372	Thromboendarterectomy, with or without patch graft; deep (profunda) femoral	12.28
3) 43631	Gastrectomy, partial, distal; with gastroduodenostomy	18.10
4) 47130	Hepatectomy, resection of liver; total right lobectomy	31.56

RELATIONSHIP OF CODE UNDER SURVEY TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Construction of a reference service table (Table 3) for the 5-year reevaluation was difficult for the vascular codes since most of the vascular procedures on the MPC list were submitted for reevaluation. The SVS/ISCVS advisors asked the RUC administrative staff for assistance with construction of the reference service table; we were referred to Dr. Kwass, chair of the RUC research subcommittee to which these codes are assigned. The recommendation was to choose some vascular codes if, in our opinion they were

approximately correctly valued, as well as some reference services from the general surgery codes on the MPC list since 1) all vascular surgeons have completed a full 5 year categorical general surgery residency and are therefore familiar with general surgery cases and 2) while we are "vascular surgeons" by dint of concentrated training or fellowship programs in vascular surgery, many vascular surgeons have practices which include general surgery cases in addition to their vascular practice. Thus, while the reference services are related to the code being surveyed by pre-service work, operative time, intensity, and magnitude of the operation, in addition to post-service work and global periods, the actual operations may be dissimilar.

Comparison to 35606: The survey respondents believed that the intra-service time spent for 35583 was 1.50 times that required for 35606, the total time was 1.53 times that for 35606, and the intensity was 1.08 times that of 35606. The calculated total work ratio of 35583 to 35606 was 1.65. Applying this ratio to the current work value of 35606, results in 28.71 RVWs (17.40×1.65) for 35583. This calculation suggests that a work value for 35583 of 24 RVW is quite reasonable, using 35606 as a reference code. Additional time and intensity data for 35606 from the Summary of Work and Time Estimates for Services Undergoing Investigation (AMA/RUC 6/8/95) were not available for analysis.

Comparison to E/M Codes: The work of 35583 may be calculated as the sum of the following E/M services, using intensive care codes as the best comparison to the complex intra-service work involved in this code:

<u>Service</u>	<u>Time</u>	<u>E/M Code</u>	<u>RVW</u>
Pre-Service	90	99215	1.51
Intra-service	220	99291 + 99292 x 5	12.84
Post-day of proc	40	99291	3.64
POD #1 ICU	30	99291	3.64
POD #2-9	10	99231 x 8	4.08
POD #10 Disch	10	99238	1.06
Office x 3	40	99213 x 2.5	1.37
Total			28.14

Thus, by using the E/M reference service building-block method, the work of 35583 computes to 28.14 units and further justifies an RVW of 24.

RATIONALE:

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The recommended increase in RVW is based upon improvements in the accuracy of existing Harvard work, time, and intensity data for this code.

- 1. Work:** The Harvard work value was originally estimated at 17.95 units by a panel without substantial participation by vascular surgeons as discussed in the Introduction. The RVW was decreased to 16.54 in 1992 and decreased further to 15.97 in 1994. The median RVW of the current survey is 24.00 units. Comparison of 35583 to 35606 results in a work value of 28.71. In addition, the E/M building block calculation of 28.14 units compares favorably with the recommended RVW of 24.00. Finally, the work survey reported by the American College of Surgeons in their February 6, 1995 Comment to HCFA (Appendix VIII of that report) suggests a slightly lower work value of 22.28 units.
- 2. Time:** The Harvard intra-service time is 188 minutes, while several more recent and more accurate methods indicate that the true intra-service time is much longer. Our median survey intra-service time was 220 minutes. The survey also requested that physicians report the actual times for their last three procedures. The median value for those procedures was 240 minutes. The survey also requested respondents to supply actual time data from their hospitals, and the volume weighted mean of these institution's median times was 205 minutes. Finally, the SVS 10 hospital OR data analysis (Table 1) revealed that the median time was 228 minutes. Considered together, these data suggest that 220 minutes is a far more accurate measure of intra-service time than the 188 minutes suggested by Harvard. Likewise, the Harvard data give a figure of 72.5 minutes for pre-service time, whereas the median survey pre-service time was 90 minutes. The Harvard post-service time was 167.5 minutes, whereas the survey post-service time was 200 minutes. The Harvard survey did not include an ICU day; however, an ICU day is common after a limb salvage operation in a patient with many comorbidities who is likely to have an arterial line and an epidural catheter in place (none of our respondents felt that our vignette was atypical).
- 3. Intensity:** The intensity of 35583 is high with a median mental effort/judgment of 4, a median technical skill value of 4, and median psychological stress value of 4. While intensity is difficult to compute back to work values, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. The IWPUT for 35583 in 1995 is 0.042 based on our SVS 10 hospital data analysis of OR log times for procedures (Table 1). It is 0.057 according to the Summary of Work and Time Estimates for Services Undergoing Investigation (AMA/RUC 6/8/95). This is less than that accorded most other major procedures in all other specialties. If 35583 is recalculated using an IWPUT of 0.07 (the low end of the spectrum of major complicated and at least moderately intense procedures), a more accurate reflection of intra-service is achieved. By this technique, intra work is $220 \times .07 = 15.40$ units. Since intra-work is 49% of the total work based on the survey data, the total work is $15.40 / .49 = 31.43$ units (see attached Appendix for an expanded discussion). Thus, this third and entirely different method of calculating work strongly supports the survey request of 24 units.
- 4. Summary:** Five different analyses suggest work values ranging from 22.28 to 31.43 for this service:
 1. The median opinion of our respondents was a request of 24.

2. Comparison to the most frequently used reference service, CPT 35606, by our survey respondents suggests a value of 28.71.
3. The E/M building block method results in an estimate of 28.14.
4. The results of the American College of Surgeons survey suggested 22.28.
5. The IWPUT method, using the most conservative IWPUT figures, justified an RVW of 31.43.

After careful review of the survey results and 4 supplemental work analyses for 35583, we recommend an RVW of 24.00.

Appendix: IWPUT Method for work calculation of 35583

1. Intra-service work per unit time (IWPUT) ranges from 0.05 to 0.12 for virtually all surgical services.
2. Intra-service work per unit time (IWPUT) ranged from 0.026 to 0.12 in the SVS Operative Log Data analysis presented in Table 1.
3. The median IWPUT for the 12 non-vascular operations in Table 1 was 0.082. Almost all major operations with reasonably high level of intensity will have an IWPUT of at least 0.070. Almost all major vascular procedures have an IWPUT of less than 0.070.
4. The performance of 35583 with its attendant risks of cardiac complications, failure, and possible limb loss should merit at least the low end of the usual spectrum of major complicated and at least moderately intense procedures. (The survey intensity ratings would actually support more than a low-end IWPUT level.)
5. The Survey intra-service median time for 35583 of 220 minutes is substantiated by our original OR log data analysis (228 min).
6. The intra-service work for 35583 should equal the operative time multiplied by the low end major surgical IWPUT, or $220 \times 0.070 = 15.4$.
7. The pre- and post- service work for 35583 are at least typical of the average operation of large magnitude in that patients presenting for this operation commonly suffer from symptomatic coronary disease, hypertension, diabetes, hyperlipidemia, obesity and COPD.
8. The RUC survey data indicate that intra-service work represents 0.49 of total work. In other words $\text{total work} = \text{intra-work} / 0.49$.
9. The total work of 35583, based on a low end of the spectrum (0.070) IWPUT value, should be $15.4 / 0.49 = 31.43$.

Public Comments

30-Jun-95

Code: 35583

1995 RVUs: 15.97

Recommended RVUs: 22.96

Ratio:

Long Descriptor: In-situ vein bypass; femoral-popliteal

Reference Set (y/n): N

Global Period: 090

Frequency: 4,266

Impact: 29819

Source: 2

Year: 92

Public Comment Letter: 337

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SVS

Societies Wishing to Comment: ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
35583	45.4	7.7	12.6	46.9	8.5	0.8	6.2	12.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
35583	4649	4864	2.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
35583	98.4	99.3	0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
35583	cardiac surgery	2.9
	general surgery	45.4
	group practices	2.6
	thoracic surgery	15.4
	vascular surgery	30.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
35583	440	5	ATHEROSCLEROSIS
	442	1.3	OTHER ANEURYSM

Public Comments

30-Jun-95

443	6.2	OTHER PERIPHERAL VASCULAR DISEAS
444	9.2	ARTERIAL EMBOLISM AND THROMBOSI
707	1.5	CHRONIC ULCER OF SKIN
728	1.5	DISORDERS OF MUSCLE, LIGAMENT, AN
785	2.3	SYMPTOMS INVOLVING CARDIOVASCUL

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
35583							
SVS		090	090	17.95	15.97	0.89	16.54

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
35583								
SVS	16.54	15.97	0.92	1.00	0.97	1.00	22.96	337

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
35583								
SVS	090	17.95		40	*	188		65

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
35583									
SVS	*	1.0		10	9.0	*	10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
35583									
SVS	*	10		22.96	15.97	gs	3		0.057

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 35585 Global Period: 090 1995 RVW: 19.05 Recommended RVW: 27.00

CPT Descriptor: In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 11 vascular surgeons designed a study to measure the major component of work for vascular surgical procedures by collecting and analyzing accurate intraoperative surgery time (skin-to-skin) of commonly performed vascular and non-vascular procedures. Data were collected from operative logs and computer databases at ten hospitals, both private and University. Median intra-service time and intra-service work per minute (IWPUT) were calculated (Table 1). The results of this study found the intra-service work of code 35585 to be significantly undervalued based on a comparison with typical "signature" procedures from many other surgical disciplines. These intra-service work comparisons formed the basis for choosing procedures to be surveyed for all aspects of work in the five-year review.

1994 Frequency of Service: 8,874

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78 year old male with a 63 pack-year history of smoking presents with a history of a non healing ulcer over his left first metatarsal. He has long standing hypertension, recent diabetes controlled with oral medication, and mild angina on occasion. He has had a previous coronary artery bypass eleven years before, and the right saphenous vein was used. He has worsening pain in his foot at rest. Arteriography, as an out-patient, revealed an occlusion of his superficial femoral artery and reconstitution of the posterior tibial artery at the level of his medial malleolus. His anterior tibial artery and his peroneal artery were not acceptable out-flow conduits. Cardiac evaluation is done as an out-patient. He is admitted to the hospital; appropriate invasive monitoring is done, an epidural catheter is inserted for anesthesia, and a femoral-posterior tibial bypass using *in situ* saphenous vein is constructed. Postoperatively he spends one day in the ICU, and is able to be discharged from the hospital on the tenth postoperative day with a palpable posterior pulse.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before the operation until the beginning of the procedure. This includes obtaining and reviewing pre-procedural work-up, with special attention to cardiopulmonary and hematologic status; reviewing previous imaging studies (especially arteriograms) and laboratory studies; consulting with the referring physician and cardiologist, if necessary, and other health care professionals; and communicating with the patient and patient's family to review the operative risks, benefits, and alternative treatments, and to obtain informed consent. Other pre-operative services include dressing, being present while appropriate invasive monitoring is done with insertion of a Swan-Ganz catheter (if necessary), arterial line, and Foley catheter. Sequential compression devices (on the contralateral leg if desired by the surgeon) are applied and placement of non-invasive ECG and oxygen saturation monitoring devices, and satisfactory anesthesia, generally consisting of insertion of an epidural catheter (or establishing general anesthesia via endotracheal inhalation), is achieved. Additional pre-operative services include ensuring that sufficient blood,

especially if the patient has previously donated blood, is available, that the surgical instruments and supplies that might be necessary are available in the operative suite, scrubbing and supervision of the positioning, prepping, and draping of the patient. Appropriate lines are connected including electrocautery and suction tubes.

Description of Intra-Service work: An incision is made in the groin and the common femoral, superficial femoral, and profunda femoris arteries as well as the greater saphenous vein are isolated and encircled. The incision is then extended down the thigh and lower leg over the greater saphenous vein until sufficient vein is exposed to allow the bypass to be constructed using one continuous segment of vein for the bypass. This usually requires an incision from the groin to near the ankle. The point for the distal anastomosis is identified, an incision is made, and the distal artery is exposed. The branches of the vein are carefully dissected and ligated with meticulous attention to making sure the saphenous vein wall itself is not damaged. The proximal end of the vein is then anastomosed to the femoral artery in an end-of-vein to side-of-artery fashion. The distal vein is divided and mobilized sufficiently to allow an anastomosis of the distal vein to the distal artery. The vein valves are then disrupted mechanically and the vein conduit is flushed with arterial flow to make sure the rate of flow is sufficient and any small bleeding points are carefully closed with fine sutures. An anastomosis, using magnification, is then made between the vein and the distal artery. Once satisfactory flow into the distal arterial circulation is determined, the incision from the groin to near the ankle is carefully closed in layers.

Description of Post-Service work: Post-service work begins after skin closure in the operating room and includes application of sterile bandages, checking the extremity for adequate arterial perfusion, and transfer of the patient to the recovery room where postoperative orders are written. Post-service work also includes stabilization of the patient in the recovery room, monitoring blood gas values as well as obtaining electrolytes and a hematocrit. It also includes communication with the family and other health care professionals (including written and oral reports and orders), all hospital visits and services performed by the surgeon, including ICU care and ventilator management as necessary, careful monitoring of cardiopulmonary, and hemodynamic status; ordering and reviewing post-operative radiographs and laboratory studies; monitoring and care of the incision which has a high incidence of incision edge necrosis; monitoring care, most especially physical therapy for training in ambulation, and removal of all tubes and drains; and antibiotics and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital and likely post hospital events, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure including removal of sutures, out-patient wound care, evaluation of periodic imaging and laboratory reports, and antibiotic and pain medication adjustments.

SURVEY DATA:**Specialty:** Society for Vascular Surgery (SVS) / International Society for Cardiovascular Surgery (ISCVS)**Sample Size:** 58 **Response Rate:** 38 (65.5%) **Median RVW:** 27**25th percentile RVW:** 23 **75th Percentile RVW:** 30 **Low:** 16.5 **High:** 55**Median Pre-Service Time:** 90 **Median Intra-Service Time:** 270**25th Percentile Intra-Svc Time:** 230 **75th Percentile Intra-Svc Time:** 318 **Low:** 140 **High:** 438

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	40	
ICU:	30	2
Other Hospital:	107.5	9
Office:	45	3

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1995 RVW</u>
1)	35606	Bypass Graft, with other than vein, carotid-subclavian	17.40
2)	35372	Thromboendarterectomy, with or without patch graft; deep (profunda) femoral	12.28
3)	47130	Hepatectomy, resection of liver; total right lobectomy	31.56
4)	43631	Gastrectomy, partial, distal; with gastroduodenostomy	18.10

RELATIONSHIP OF CODE UNDER SURVEY TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Construction of a reference service table (Table 3) for the 5-year reevaluation was difficult for the vascular codes since most of the vascular procedures on the MPC list were submitted for reevaluation. The SVS/ISCVS advisors asked the RUC administrative staff for assistance with construction of the reference service table; we were referred to Dr. Kwass, chair of the RUC research subcommittee to which these codes are assigned. The recommendation was to choose some vascular codes if, in our opinion they were approximately correctly valued, as well as some reference services from the general surgery codes on the MPC list since 1) all vascular surgeons have completed a full 5 year categorical general surgery residency

and are therefore familiar with general surgery cases and 2) while we are "vascular surgeons" by dint of concentrated training or fellowship programs in vascular surgery, many vascular surgeons have practices which include general surgery cases in addition to their vascular practice. Thus, while the reference services are related to the code being surveyed by pre-service work, operative time, intensity, and magnitude of the operation, in addition to post-service work and global periods, the actual operations may be dissimilar.

Comparison to 35606: The survey respondents believed that the intra-service time spent for 35585 was 1.74 times that required for 35606, the total time was 1.62 times that for 35606, and the intensity was 1.15 times that of 35606. The calculated total work ratio was 1.96 times that of 35606. Applying this ratio to the current work value of 35606 (17.40 RVWs), results in **34.10 RVWs** for 35585 (17.40 x 1.96). This comparison, therefore, suggests that a work value for 35585 of 27 RVW is quite reasonable, using 35606 as a reference code. Additional time and intensity data for 35606 from the Summary of Work and Time Estimates for Services Undergoing Investigation (AMA/RUC 6/8/95) were not available for analysis.

Comparison to E/M Codes: The work of 35585 may be calculated as the sum of the following E/M services, using intensive care codes as the best comparison to the complex intra-service work involved with this service:

<u>Service</u>	<u>Time</u>	<u>E/M Code</u>	<u>RVW</u>
Pre-Service	90	99215	1.51
Intra-service	270	99291 + 99292 x 7	16.52
Post-day of proc	40	99291	3.64
POD #1 ICU	30	99291	3.64
POD #2-9	10	99231 x 8	4.08
POD #10 Disch	35	99238	1.06
Office x 3	45	99213 x 3	1.65
Total			32.10

Thus, by using the E/M reference service building-block method, the work of 35585 should be **32.10 units**.

RATIONALE:

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The recommended increase in RVW is based upon improvements in the accuracy of existing Harvard work, time, and intensity data for this code.

1. Work: The Harvard work value was originally estimated at 20.89 units by a panel without substantial participation by vascular surgeons as discussed in the Introduction. The RVU was decreased to 19.72 in 1992 and decreased further to 19.05 in 1994. The median RVW of the current survey is 27 units. The median survey value is easily justified by comparison to the most frequently used reference service, CPT 35606, which results in a value of 34.10. The E/M building block calculation of 32.10 units also compares favorably with the recommended RVW of 27.00. In addition, the work survey reported by the American College of Surgeons in their February 6, 1995 Comment to HCFA (Appendix VIII in that report) suggests a work value of 28.18 for this service.

2. Time: The Harvard intra-service time is 233 minutes, while several more recent and more accurate methods indicate that the true intra-service time is considerably longer. Our median survey intra-service time was 270 minutes. The survey also requested that physicians report the actual times for their last three procedures. The median value for those procedures was 278 minutes. The survey also requested respondents to supply actual time data from their hospitals, and the volume weighted mean of these institution's median times was 273 minutes. Finally, the SVS 10 hospital OR data analysis (Table 1) revealed that the median time was 261 minutes. Considered together, these data suggest that 270 minutes is a far more accurate measure of intra-service time than 233 minutes. Likewise, the Harvard data give a figure of 68.5 minutes for pre-service time, whereas the median survey pre-service time was 90 minutes. The Harvard post-service time was 172.5 minutes, whereas the survey time was 222.5 minutes. The Harvard survey did not include an ICU day; however, this is common after a limb salvage operation in a patient with many comorbidities who is likely to have an arterial line and an epidural catheter in place (only 1 of our respondents felt that our vignette was atypical).

3. Intensity: The intensity of 35585 is very high with a median mental effort/judgment of 4, a median technical skill value of 4, and median psychological stress value of 4. While intensity is difficult to compute back to work values, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. The IWPUT for 35585 in 1995 is 0.048 based on our SVS 10 hospital data analysis of OR log times for procedures (Table 1). It is 0.059 according to the Summary of Work and Time Estimates for Services Undergoing Investigation (AMA/RUC 6/8/95). This is considerably less than that accorded most other procedures in all other specialties. If 35585 is recalculated using an IWPUT of 0.07 (the low end of the spectrum of major complicated and at least moderately intense procedures), a more accurate reflection of intra-service time is achieved. By this technique, intra-work is $270 \times 0.07 = 18.90$ units. Since intra-work is 51% of the total work based on the survey data, the total work is $18.90/0.51 = 37.06$ units (see attached Appendix for an expanded discussion). Thus, this third and entirely different method of calculating work strongly supports the survey request of 27 units.

4. Summary: Five different analyses suggest work values from 27.00 to 37.06:

1. Median survey value is 27.00.
2. Comparison to reference code 35606 suggests a work value of 34.10.
3. The E/M building block method results in an estimate of 32.10.
4. The American College of Surgeons survey suggested 28.18.

5. The IWPUT method, using conservative IWPUT figures, justifies a value of 37.06.

After careful review of the survey results and supplemental work analyses for 35585, we recommend an RVW of 27.00.

Appendix: IWPUT Method for work calculation of 35585

1. Intra-service work per unit time (IWPUT) ranges from 0.05 to 0.12 for virtually all surgical services.
2. Intra-service work per unit time (IWPUT) ranged from 0.026 to 0.12 in the SVS Operative Log Data analysis presented in Table 1.
3. The median IWPUT for the 12 non-vascular operations in Table 1 was 0.082. Almost all major operations with reasonably high level of intensity will have an IWPUT of at least 0.070. Almost all major vascular procedures have an IWPUT of less than 0.070.
4. The performance of 35585 with its attendant risks of cardiac complications, failure, and possible limb loss should merit at least the low end of the usual spectrum of major complicated and at least moderately intense procedures. (The survey intensity ratings would actually support more than a low-end IWPUT level.)
5. The Survey intra-service median time for 35585 of 270 minutes is substantiated by our original OR log data analysis (261 min).
6. The intra-service work for 35585 should equal the operative time multiplied by the low end major surgical IWPUT, or $270 \times 0.070 = 18.9$.
7. The pre- and post- service work for 35585 are at least typical of the average operation of large magnitude in that patients presenting for this operation commonly suffer from symptomatic coronary disease, hypertension, diabetes, hyperlipidemia, obesity and COPD.
8. The RUC survey data indicate that intra-service work represents 0.51 of total work. In other words $\text{total work} = \text{intra-work} / 0.51$.
9. The total work of 35585, based on a low end of the spectrum (0.07) IWPUT value, should be $18.9/0.51 = 37.06$.

Public Comments

30-Jun-95

Code: 35585

1995 RVUs: 19.05

Recommended RVUs: 27.39

Ratio:

Long Descriptor: In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery

Reference Set (y/n): N

Global Period: 090

Frequency: 7,489

Impact: 62458

Source: 4

Year: 93

Public Comment Letter: 337

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SVS

Societies Wishing to Comment: ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
35585	46.6	12.1	20	42.2	7.8	1.9	7.3	12.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
35585	7885	8874	6.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
35585	98.6	99.3	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
35585	cardiac surgery	3
	general surgery	45.9
	group practices	3.3
	thoracic surgery	12.1
	vascular surgery	31.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
35585	250	1.9	DIABETES MELLITUS
	440	8.1	ATHEROSCLEROSIS

Public Comments

30-Jun-95

443	6.7	OTHER PERIPHERAL VASCULAR DISEAS
444	6.1	ARTERIAL EMBOLISM AND THROMBOSI
447	1.7	OTHER DISORDERS OF ARTERIES AND A
459	2.2	OTHER DISORDERS OF CIRCULATORY S
707	3.2	CHRONIC ULCER OF SKIN
785	4.2	SYMPTOMS INVOLVING CARDIOVASCUL

Harvard Data:

Comm	Modif	Packlv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
35585							
SVS		090	090	20.89	19.05	0.91	19.72

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
35585								
SVS	19.72	19.05	0.94	1.00	0.97	1.00	27.39	337

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
35585								
SVS	090	20.89		36		233		65

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
35585									
SVS		1.0		10	9.5		10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
35585									
SVS		10		27.39	19.05	gs	3		0.059

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 35656 **Global Period:** 090 1995 **RVW:** 13.86 **Recommended RVW:** 18.00

CPT Descriptor: Bypass graft, with other than vein; femoral-popliteal

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 11 vascular surgeons designed a study to measure the major component of work for vascular surgical procedures by collecting and analyzing accurate intraoperative surgery time (skin-to-skin) of commonly performed vascular and non-vascular procedures. Data were collected from operative logs and computer databases at ten hospitals, both private and University. Median intra-Service time and intra-service work per minute (IWPUT) were calculated (Table 1). The results of this study found the intra-service work of code 35656 to be significantly undervalued based on a comparison with typical "signature" procedures from many other surgical disciplines. These intra-service work comparisons formed the basis for choosing procedures to be surveyed for all aspects of work in the five-year review.

1994 Frequency of Service: 21,644

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A vigorous 72 year old male with a 50 pack-year history of smoking and long standing hypertension presents with severe claudication limiting him to walking 1/4 block. He still works and finds these symptoms extremely life style limiting. Arteriography as an out-patient reveals an occlusion of the superficial femoral artery at the groin with reconstitution of the popliteal artery above the knee. Two of the three distal tibial vessels are open. Cardiac evaluation is done as an out-patient. He is admitted to the hospital a week after the arteriogram and appropriate invasive monitoring is done. On the day of admission an epidural catheter is inserted for anesthesia and a femoral-popliteal bypass above the knee is constructed with a PTFE graft. The patient does not require stay in the ICU and is able to walk and be discharged on the sixth postoperative day.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before the operation until the beginning of the procedure. This includes obtaining and reviewing pre-procedural work-up, with special attention to cardiopulmonary and hematologic status; reviewing previous imaging studies (especially arteriograms) and laboratory studies; consulting with the referring physician and cardiologist, if necessary, and other health care professionals; and communicating with the patient and patient's family to review the operative risks, benefits, and alternative treatments, and to obtain informed consent. Other pre-operative services include dressing, being present while appropriate invasive monitoring is done with insertion of a Swan-Ganz catheter and arterial line, if necessary, and a Foley catheter. Sequential compression devices (on the contralateral leg if desired by the surgeon) are applied and placement of non-invasive ECG and oxygen saturation monitoring devices, and satisfactory anesthesia, generally consisting of insertion of an epidural catheter (or establishing general anesthesia via endotracheal inhalation), is achieved. Additional pre-operative services include ensuring that sufficient blood is available, that the surgical instruments and supplies that might be necessary are available in the operative suite, scrubbing and supervision of the positioning, prepping, and draping of the patient. Appropriate lines are connected including electrocautery and suction tubes.

Description of Intra-Service work: An incision is made in the groin and the common femoral, superficial femoral, and profunda femoris arteries are isolated and encircled. A separate incision (almost always above the knee) is made and the popliteal artery is likewise identified, mobilized and encircled. A suitable prosthetic graft is selected and anastomosed to the femoral artery in the groin in an end-of-graft to side-of-artery fashion. Once there is no bleeding from the suture line, the graft is tunneled beneath the thigh muscles to the popliteal artery where a second anastomosis is performed. Once all bleeding is controlled and satisfactory flow into the distal arterial circulation is determined, the two incisions (groin and above-knee) are carefully closed in layers.

Description of Post-Service work: Post-service work begins after skin closure in the operating room and includes application of sterile bandages, checking the extremity for adequate arterial perfusion, and transfer of the patient to the recovery room where postoperative orders are written. Post-service work also includes stabilization of the patient in the recovery room and monitoring blood values. It also includes communication with the family and other health care professionals (including written and oral reports and orders), all hospital visits and services performed by the surgeon, careful monitoring of cardiopulmonary, and hemodynamic status; ordering and reviewing post-operative radiographs and laboratory studies; monitoring care, most especially physical therapy for training in ambulation, and antibiotics and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the hospital and likely post hospital events, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure including removal of sutures, out-patient wound care, evaluation of periodic imaging and laboratory reports, and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: Society for Vascular Surgery (SVS) / International Society for Cardiovascular Surgery (ISCVS)

Sample Size: 58 Response Rate: 39 (67.2%) Median RVW: 18

25th percentile RVW: 15 75th Percentile RVW: 20 Low: 9 High: 30

Median Pre-Service Time: 90 Median Intra-Service Time: 150

25th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 180 Low: 60 High: 260

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	30	
ICU:	0	0
Other Hospital:	72.5	6
Office:	40	2

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1995 RVW</u>
1)	35606	Bypass Graft, with other than vein, carotid-subclavian	17.40
2)	35372	Thromboendarterectomy, with or without patch graft; deep (profunda) femoral	12.28
3)	43631	Gastrectomy, partial, distal; with gastroduodenostomy	18.10
4)	27880	Amputation, leg through tibia and fibula	10.69

RELATIONSHIP OF CODE UNDER SURVEY TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Construction of a reference service table (Table 3) for the 5-year reevaluation was difficult for the vascular codes since most of the vascular procedures on the MPC list were submitted for reevaluation. The SVS/ISCVS advisors asked the RUC administrative staff for assistance with construction of the reference service table; we were referred to Dr. Kwass, chair of the RUC research subcommittee to which these codes are assigned. The recommendation was to choose some vascular codes if, in our opinion they were

approximately correctly valued, as well as some reference services from the general surgery codes on the MPC list since 1) all vascular surgeons have completed a full 5 year categorical general surgery residency and are therefore familiar with general surgery cases and 2) while we are "vascular surgeons" by dint of concentrated training or fellowship programs in vascular surgery, many vascular surgeons have practices which include general surgery cases in addition to their vascular practice. Thus, while the reference services are related to the code being surveyed by pre-service work, operative time, intensity, and magnitude of the operation, in addition to post-service work and global periods, the actual operations may be dissimilar.

Comparison to 35606: The survey respondents believed that the intra-service time spent for 35656 was 1.01 times that required for 35606, the total time was 1.14 times that for 35606, and the intensity was 0.89 times that of 35606. The calculated total work was 1.01 that of 35606, indicating that the total work of 35656 is similar to that of 35606. If the ratio of 1.01 is applied to the current value of 35606 (17.40 RVWs), the result is 17.57 work units for 35656. This comparison closely approximates the recommended work value for 35656 of 18 RVW and suggests that the current value of 13.86 does not adequately reflect the work of this service. Additional time and intensity data for 35606 from the Summary of Work and Time Estimates for Services Undergoing Investigation (AMA/RUC 6/8/95) were not available for analysis.

Comparison to E/M Codes: The work of 35656 may be calculated as the sum of the following E/M services, using intensive care codes as the best comparison to the complex intra-service work involved in this service:

<u>Service</u>	<u>Time</u>	<u>E/M Code</u>	<u>RVW</u>
Pre-Service	90	99215	1.51
Intra-service	150	99291 + 99292 x 3	9.16
Post-day of proc	30	99291	3.64
POD #1-5	10	99231 x 4	2.04
POD #6 Disch	22.5	99238	1.06
Office x 2	40	99213 x 2	1.10
Total			18.51

Thus, by using the E/M reference service building-block method, the work of 35656 should be 18.51 units, further justifying an RVW of 18.00.

RATIONALE:

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The recommended increase in RVW is based upon improvements in the accuracy of existing Harvard work, time, and intensity data for this code.

1. Work: The Harvard work value was originally estimated at 15.49 units by a panel without substantial participation by vascular surgeons as discussed in the Introduction. The RVW was decreased to 14.53 in 1992 and decreased further to 13.86 in 1994. The median RVW of the current survey is 18 units. The median RVW is reinforced by comparison to the key reference service which results in an equivalent value of 17.57 units. The E/M building block calculation of 18.51 units also compares favorably with the requested RVW of 18. In addition, the American College of Surgeons in their February 6, 1995 Comment to HCFA (Appendix VIII in that report) suggests a work value of 19.33 for this service.

2. Time: The Harvard intra-service time is 148 minutes, consistent with the median value revealed in our survey of 150 minutes. The survey also requested that physicians report the actual times for their last three procedures. The median value for those procedures was 165 minutes. The survey also requested respondents to supply actual time data for their hospitals, and the volume weighted mean of these institution's median times was 158 minutes. Finally, the SVS 10 hospital OR data analysis (Table 1) revealed that the median time was 170 minutes. Considered together, these data suggest that 150 minutes is a conservative estimate of the median time. The Harvard data give a figure of 69.5 minutes for pre-service time, whereas the median survey pre-service time was 90 minutes. The Harvard post-service time was 157.5 minutes, whereas the survey post-service time was 142.5 minutes.

3. Intensity: The intensity of 35656 is moderate with a median mental effort/judgment of 3, a median technical skill value of 3, and median psychological stress value of 3. While intensity is difficult to compute back to work values, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. The IWPUT for 35656 in 1995 is 0.048 based on our SVS 10 hospital data analysis of OR log times for procedures (Table 1). It is 0.062 according to the Summary of Work and Time Estimates for Services Undergoing Investigation (AMA/RUC 6/8/95). This is less than that accorded most other major procedures in all other specialties. If 35656 is recalculated using an IWPUT of 0.07 (the low end of the spectrum of major complicated and at least moderately intense procedures), a more accurate reflection of intra-service intensity is achieved. By this technique, intra work is $150 \times .07 = 10.50$ units. Since intra-work is 56% of the total work based on the survey data, the total work is $10.50 / .56 = 18.75$ units (see attached Appendix for an expanded discussion). Thus, this method of calculating work supports the survey request of 18 units.

4. Summary: Five different analyses suggest work values of 17.57 to 19.33 for this service:

1. Median survey value is **18.00**.
2. Comparison to the reference code 35606 suggests a work value of **17.57**.
3. The E/M building block method results in an estimate of **18.51**.
4. The American College of Surgeons survey suggested **19.33**.
5. The IWPUT method, using conservative IWPUT figures, justifies an RVW of **18.75**.

After careful review of the survey results and supplemental work analyses for 35656, we recommend an RVW of **18.00**.

Appendix: IWPUT Method for work calculation of 35656

1. Intra-service work per unit time (IWPUT) ranges from 0.05 to 0.12 for virtually all surgical services.
2. Intra-service work per unit time (IWPUT) ranged from 0.026 to 0.12 in the SVS Operative Log Data analysis presented in Table 1.
3. The median IWPUT for the 12 non-vascular operations in Table 1 was 0.082. Almost all major operations with reasonably high level of intensity will have an IWPUT of at least 0.070. Almost all major vascular procedures have an IWPUT of less than 0.070.
4. The performance of 35656 with its attendant risks of cardiac complications, failure, and possible limb loss should merit at least the low end of the usual spectrum of major complicated and at least moderately intense procedures.
5. The Survey intra-service median time for 35656 of 150 minutes is substantiated by our original OR log data analysis (170 min).
6. The intra-service work for 35656 should equal the operative time multiplied by the low end major surgical IWPUT, or $150 \times 0.070 = 10.5$.
7. The pre- and post- service work for 35656 are at least typical of the average operation of large magnitude in that patients presenting for this operation commonly suffer from symptomatic coronary disease, hypertension, diabetes, hyperlipidemia, obesity and COPD.
8. The RUC survey data indicate that intra-service work represents 0.56 of total work. In other words $\text{total work} = \text{intra-work} / 0.56$.
9. The total work of 35656, based on a low end of the spectrum (0.070) IWPUT value, should be $10.5 / 0.56 = 18.75$.

Public Comments

30-Jun-95

Code: 35656

1995 RVUs: 13.86

Recommended RVUs: 18.73

Ratio:

Long Descriptor: Bypass graft, with other than vein; femoral-popliteal

Reference Set (y/n): Y

Global Period: 090

Frequency: 18,970

Impact: 92384

Source: 1

Year: 92

Public Comment Letter: 185

Reference Services:

CMD Comment:

Societies Wishing to Survey: SVS

Societies Wishing to Comment: ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
35656	39.4	7	14.1	47	9	0.8	3.7	9.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
35656	19766	21644	4.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
35656	98.2	99.2	0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
35656	anesthesiology	2.8
	cardiac surgery	4.8
	cardiovascular disease	2.3
	general surgery	42.9
	group practices	2.6
	thoracic surgery	21.2
	vascular surgery	21.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
35656			

Public Comments

30-Jun-95

440	7.3	ATHEROSCLEROSIS
443	7.3	OTHER PERIPHERAL VASCULAR DISEAS
444	9.5	ARTERIAL EMBOLISM AND THROMBOSI
447	1.6	OTHER DISORDERS OF ARTERIES AND A
459	1.9	OTHER DISORDERS OF CIRCULATORY S
785	2	SYMPTOMS INVOLVING CARDIOVASCUL

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
35656							
ASGS		090	090	15.49	13.86	0.89	14.53
SVS		090	090	15.49	13.86	0.89	14.53

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
35656								
ASGS	14.53	13.86	0.94	1.00	0.95	1.00	18.73	185
SVS	14.53	13.86	0.94	1.00	0.95	1.00	16.86	337

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ftime	Notett	Imppt
35656								
ASGS	090	15.49		37		148		65
SVS	090	15.49		37		148		65

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
35656									
ASGS		1.0		10	7.0		10	0.0	4.5
SVS		1.0		10	7.0		10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
35656									
ASGS		10		18.73	13.86	gs	n		0.062
SVS		10		16.86	13.86	gs	n		0.062

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 36215 Global Period: .XXX Current RVW: 4.47 Recommended RVW: 5.07

CPT Descriptor: Selective catheter placement arterial system: each first order of thoracic or brachiocephalic branch within a vascular family.

Source and Summary of Comment to HCFA on this service: SCVIR. The work value of 36215 should be raised to that of 36245 because of inherent equivalence of work.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Specialty: _____

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time: _____ Total Time _____ Number of Visits _____

Day of Procedure: _____

ICU:

Other Hospital:

Office:

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	36215	Selective arterial catheter placement, first order abdominal branch.	5.07
2)			
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

See Rationale

RATIONALE

Two parallel groups of codes describe selective catheter placement in noncoronary arteries: 36245 through 36248 describing placement of a catheter in arteries below the diaphragm and 36215 through 36218 describing selective arterial catheter placement in thoracic or brachiocephalic arteries above the diaphragm.

Harvard data showed that the work of second and third order arterial catheterizations was equivalent whether above or below the diaphragm. Thus, in the current Medicare Fee Schedule the work of 36216 equals the work of 36246, the work of 36217 equals the work of 36247, and the work of 36218 equals the work of 36248. The Harvard study, however, did show a difference in the work of 36215 and 36245, and these codes were thus assigned different work RVUs in the 1992 Medicare Fee Schedule.

While we understand that the Harvard data showed dissimilar work for 36215 and 36245, we believe that the Harvard data is flawed. We predominantly believe this because radiologists or interventional radiologists were not surveyed despite the fact that current Medicare provider files show that radiologists and interventionalists provide 68.9 percent of the total services in 1994 and 83.6 percent of the total 36215 services. Original SCVIR survey data (conducted in 1991 during

construction of an Interventional Radiology RVS) shows that the work involved in 36215 and 36245 was virtually identical. That survey data is included in Appendix A. Despite several comments to HCFA by SCVIR that the work of 36215 should be at least as high as the work of 36245, no change in the Medicare Fee Schedule has been made. We believe that the work value of 36215 should be raised to that of 36245 for the following reasons:

- 1) **Inherent equivalence of work.** It is illogical that first order catheterization in one family (above the diaphragm) should be given a lower work value than an identical service performed below the diaphragm. In reality, many interventionalists would argue that cerebrovascular arterial catheterization is more work than abdominal arterial catheterization.
- 2.) **Confirmation of equivalence by other survey data.** The equivalence of 36215 and 36245 was confirmed by a SCVIR survey in 1991 using Harvard methodology.

We therefore request that the value of CPT 36215 be raised to that of CPT 36245 (RVW 5.07).

Public Comments

30-Jun-95

Code: 36215

1995 RVUs: 4.47

Recommended RVUs: 5.07

Ratio:

Long Descriptor: Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family

Reference Set (y/n): Y **Global Period:** XXX **Frequency:** 102,522 **Impact:** 61513

Source: 4 **Year:** 93 **Public Comment Letter:** 317

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SCVIR

Societies Wishing to Comment: ACEP, ACR, ASIM, RPA

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
36215	44.3	5.2	7.1	45.8	6.1	0.7	1.4	10.3

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
36215	109495	115850	2.9

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
36215	65.2	62.4	-1.4

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
36215	cardiovascular disease	6.7
	group practices	4.2
	interventional radiolog	5.4
	radiology	76.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
36215	414	1.3	OTHER FORMS OF CHRONIC ISCHEMIC H
	433	12.7	OCCCLUSION AND STENOSIS OF PRECERE

Public Comments

30-Jun-95

435	2.1	TRANSIENT CEREBRAL ISCHEMIA
436	1.2	ACUTE, BUT ILL-DEFINED, CEREBROVAS
447	1.3	OTHER DISORDERS OF ARTERIES AND A
786	1.1	SYMPTOMS INVOLVING RESPIRATORY S
V72	8.6	SPECIAL INVESTIGATIONS AND EXAMIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
36215							
SCVIR		ZZZ	XXX	2.15	4.47	2.08	4.47

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
36215								
SCVIR	4.47	4.47	2.08	1.00	1.00	1.00	5.07	317

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
36215								
SCVIR	XXX	2.15	t	0	*	61	t	0

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
36215									
SCVIR	*	0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
36215									
SCVIR	*	0	j	5.07	4.47	gs	3	0.035	

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 36218 Global Period: XXX Current RVW: 1.01 Recommended RVW: 2.74

CPT Descriptor: Selective catheter placement, arterial system, additional second order, third order, and beyond, thoracic or brachial branch within a vascular family.

Source and Summary of Comment to HCFA on this service: SCVIR. Raise 36218 and 36248 to levels appropriate to original SCVIR survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Specialty: _____

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure:

ICU:

Other Hospital:

Office:

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	36246	Initial second order abdominal... artery branch	5.28
2)	36247	Initial third order abdominal... artery branch	6.30
3)	36216	Initial second order thoracic... artery branch	5.28
4)	36217	Initial third order thoracic... artery branch	6.30

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

See Rationale

RATIONALE

The above two codes are used to describe further second, third, and fourth order catheterization after the initial most selective catheterization has been achieved. SCVIR believes that the RVWs for codes 36218 and 36248 are inappropriately low. Practicing interventionalists are uniformly of the opinion that placement of a catheter in an additional second, third, or fourth order branch is frequently the most time and labor intensive aspect of selective and superselective arterial catheterization. For example, a physician who performs catheterization of the splenic artery off the celiac (a second order catheterization) and then performs selective hepatic arterial catheterization, another second order placement will frequently spend an additional amount of time greater than the time taken to catheterize the splenic artery. Such an activity will often require a change of a catheter over the guidewire and the use of several different guidewires to achieve final catheter position. Yet, the current Medicare Fee Schedule pays less than one fifth of the fee that he would receive for 36246). This, we believe, represents a gross payment inequity.

The SCVIR surveyed codes 36218 and 36248 in a comprehensive study of interventional radiology codes conducted using Harvard methodology in 1991. The SCVIR survey found that 36218 and 36248 require approximately 65 percent of the work involved in 36216 and 36246, and 46 percent of that involved in 36217 and 36247. These data are included in Appendix A. Relative to these survey results, Medicare currently undervalues 36218 and 36248 significantly. The recommended work value of 2.74 would bring values closer to the SCVIR survey findings so that the work value of 36218 and 36248 would be 52 percent of that for 36216 and 36246, and 43 percent of that for

36217 and 36247.

Public Comments

30-Jun-95

Code: 36218

1995 RVUs: 1.01

Recommended RVUs: 2.75

Ratio:

Long Descriptor: Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (use in addition to 36216 or 36217 as appropriate)

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 10,387 **Impact:** 18073

Source: 2 **Year:** 92 **Public Comment Letter:** 317

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SCVIR

Societies Wishing to Comment: ACEP, ACR, ASIM, RPA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
36218	32.8	1.5	12.1	48.5	13.5	1.1	2.2	13.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
36218	10457	11625	5.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
36218	71.2	67.6	-1.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
36218	cardiovascular disease	4.6
	group practices	6
	interventional radiolog	5.8
	neurological surgery	5.6
	radiology	73.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
36218	225	1.1	BENIGN NEOPLASM OF BRAIN AND OTH

Public Comments

30-Jun-95

430	1.5	SUBARACHNOID HEMORRHAGE
433	9.7	OCCLUSION AND STENOSIS OF PRECERE
435	1.7	TRANSIENT CEREBRAL ISCHEMIA
437	1.7	OTHER AND ILL-DEFINED CEREBROVAS
747	1.3	OTHER CONGENITAL ANOMALIES OF CI
786	1.2	SYMPTOMS INVOLVING RESPIRATORY S
V72	7.1	SPECIAL INVESTIGATIONS AND EXAMIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
36218							
SCVIR			XXX		1.01		1.01

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
36218								
SCVIR	1.01	1.01		1.00	1.00	1.00	2.75	317

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
36218								
SCVIR	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
36218									
SCVIR									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
36218									
SCVIR				2.75	1.01				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 36248 Global Period: .XXX Current RVW: 1.01 Recommended RVW: 2.74

CPT Descriptor: Selective catheter placement, arterial system, additional second order, third order, and beyond, pelvic or lower extremity branch within a vascular family.

Source and Summary of Comment to HCFA on this service: SCVIR. Raise 36218 and 36248 to levels appropriate to original SCVIR survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Specialty: _____

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure:

ICU:

Other Hospital:

Office:

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	36246	Initial second order abdominal... artery branch	5.28
2)	36247	Initial third order abdominal... artery branch	6.30
3)	36216	Initial second order thoracic... artery branch	5.28
4)	36217	Initial third order thoracic... artery branch	6.30

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

See Rationale

RATIONALE

The above two codes are used to describe further second, third, and fourth order catheterization after the initial most selective catheterization has been achieved. SCVIR believes that the RVWs for codes 36218 and 36248 are inappropriately low. Practicing interventionalists are uniformly of the opinion that placement of a catheter in an additional second, third, or fourth order branch is frequently the most time and labor intensive aspect of selective and superselective arterial catheterization. For example, a physician who performs catheterization of the splenic artery off the celiac (a second order catheterization) and then performs selective hepatic arterial catheterization, another second order placement will frequently spend an additional amount of time greater than the time taken to catheterize the splenic artery. Such an activity will often require a change of a catheter over the guidewire and the use of several different guidewires to achieve final catheter position. Yet, the current Medicare Fee Schedule pays less than one fifth of the fee that he would receive for 36246). This, we believe, represents a gross payment inequity.

The SCVIR surveyed codes 36218 and 36248 in a comprehensive study of interventional radiology codes conducted using Harvard methodology in 1991. The SCVIR survey found that 36218 and 36248 require approximately 65 percent of the work involved in 36216 and 36246, and 46 percent of that involved in 36217 and 36247. These data are included in Appendix A. Relative to these survey results, Medicare currently undervalues 36218 and 36248 significantly. The recommended work value of 2.74 would bring values closer to the SCVIR survey findings so that the work value of 36218 and 36248 would be 52 percent of that for 36216 and 36246, and 43 percent of that for 36217 and 36247.

Public Comments

30-Jun-95

Code: 36248

1995 RVUs: 1.01

Recommended RVUs: 2.75

Ratio:

Long Descriptor: Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (use in addition to 36246 or 36247 as appropriate)

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 3,991 **Impact:** 6944

Source: 2 **Year:** 92 **Public Comment Letter:** 317

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SCVIR

Societies Wishing to Comment: ACEP, ACR, ASIM, RPA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
36248	35.2	10.2	12.4	54.6	21.3	0	4.6	23.5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
36248	4117	4584	5.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
36248	78.6	75.3	-1.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
36248	cardiovascular disease	17.4
	group practices	7.7
	internal medicine	2.7
	interventional radiolog	9
	radiology	59.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
36248	228	3.5	HEMANGIOMA AND LYMPHANGIOMA, A

Public Comments

30-Jun-95

250	1.4	DIABETES MELLITUS
440	1.9	ATHEROSCLEROSIS
443	5.6	OTHER PERIPHERAL VASCULAR DISEAS
444	4.4	ARTERIAL EMBOLISM AND THROMBOSI
578	1.6	GASTROINTESTINAL HEMORRHAGE
729	3.9	OTHER DISORDERS OF SOFT TISSUES
V72	6.5	SPECIAL INVESTIGATIONS AND EXAMIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
36248							
SCVIR			XXX	.	1.01	.	1.01

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
36248								
SCVIR	1.01	1.01	.	1.00	1.00	1.00	2.75	317

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
36248								
SCVIR	XXX	.		.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icurvis	Offvis
36248									
SCVIR

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
36248									
SCVIR	.	.		2.75	1.01				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 36533 **Global Period:** 010 **1995 RVW:** 3.82 **Recommended RVW:** 5.00

CPT Descriptor: Insertion of implantable venous access port, with or without subcutaneous reservoir

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 14 general surgeons, with the assistance of Abt Associates, Inc., designed a study that included a survey instrument to effectively measure all aspects of physician work for commonly performed general surgery services. The results of this study found code 36533 to be undervalued at the present time.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

42-year-old female with systemic lupus erythematosus, diabetes mellitus, and osteomyelitis of her right lower extremity needs venous access for long-term IV antibiotic therapy. She is a perfect candidate for implantable venous access with reservoir and underwent insertion of a subclavian venous access mediport. She subsequently was discharged from the hospital for long-term antibiotic therapy.

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the time of the procedure. This activity includes obtaining and reviewing previous laboratory and imaging studies, with special attention to vascular, cardiopulmonary, diabetic, and hematologic status; consulting with the referring physician, if necessary, and with other health care professionals; and communicating with the patient (and/or the patient's family) to review alternate forms of therapy for venous access, the complications and risks of those alternate forms, and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work:

After local infiltration of anesthesia, central venous access is obtained. A guide wire is introduced through the central vein into the superior vena cava. Wire position is confirmed fluoroscopically. After further local infiltration of anesthesia, a subcutaneous pocket is created in proper physical proximity to the venipuncture site. A sheath-dilator assembly is passed over the guide wire. The dilator is removed, and the catheter is placed through the peel-away sheath. The sheath is gradually removed as the catheter is advanced into position. The catheter is tunneled from the venipuncture site to the pocket and is then trimmed to a length that is appropriate for positioning within the vena cava and for reaching the reservoir without kinking. The catheter is attached to the reservoir, and the reservoir is sutured to the deep layer of the pocket. The pocket is closed in layers. Patency of the reservoir-catheter system is confirmed by aspiration and injection. Position of the system is confirmed by contrast injection. The system is primed with heparinized saline.

Description of Post-Service Work:

Post-service work begins after skin closure in the operating room and includes the application of sterile dressings; monitoring the patient's stability; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including assessment of a postoperative chest radiograph; monitoring and care of the incision, as well as the patency of the venous access port; and antibiotic and pain medication management. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 10 days after the day of the operation are considered part of the postoperative work for this procedure.

SURVEY DATA:

Specialty: American College of Surgeons

Sample Size: 175 Response Rate (%): 36 (21%)

	Median	Low	25th pctl	75th pctl	High
RVW:	5.00	4.00	4.08	5.50	7.30
PRE-Service	30				
INTRA-Service	45	25	31	60	100
POST-Service:					
Day of procedure - total time	20				
ICU - total time / # of visits	0	0			
Other hosp. - total time / # of visits	5	1			
Office - total time / # of visits	15	1			

KEY REFERENCE SERVICE(S):

1995

<u>RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
2.43	xxx	36010	Introduction of catheter, superior or inferior vena cava
3.14	xxx	36011	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)
2.00 ¹	090	62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
5.07	090	33216	Insertion, replacement or repositioning of permanent transvenous electrode(s) only (15 days or more after initial insertion); single chamber, atrial or ventricular
1.22	000	36489*	Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2
6.25	090	62350	Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable infusion pump; without laminectomy
6.29	090	63685	Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

¹This RVW recently was approved by the RUC and submitted to HCFA for the 1996 MFS.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

36533 is similar in total work to 36010, 36011, and 62360. 36010 and 36011 represent the placement of the catheter using fluoroscopic assistance, while 62360 (recently approved by RUC) represents work involved for the subcutaneous pocket. The combination of 36010 and 62360 (RVW 4.43=2.43 + 2.00) represents 80 percent of the work of 36533, with the remaining 20 percent attributable to the subcutaneous tunneling of the catheter. Additionally, connection of the catheter to the reservoir, testing the reservoir for function, and completion of venography to confirm proper placement are necessary and contribute to the total work of 36533. 36533 also is comparable in work to 62350 and 63685. However, the latter codes have 90-day global periods.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Many patients with malignant disease who require chemotherapy are candidates for this procedure. In addition, the patients requiring this service often are older, more debilitated patients with chronic antibiotic therapy needs. Medicare data show that 37 percent of patients requiring this service are 75 years of age or older.

The recommended increase in the RVW for code 36533 (from 3.82 to 5.00) also is based on an anomalous relationship with other catheter procedures currently in the *CPT Manual* and on the vertical relationship within a selected family of venous codes (36400 through 36535). In order to achieve a better relationship within the family of codes, a reduction in the RVW for code 36534 (Revision of implantable venous access port and/or subcutaneous reservoir) was recommended (from 3.79 to 2.73). This reduction was placed on the five-year review consent calendar.

It should be noted that code 36533 was valued by HCFA. Therefore, no pre-, intra-, and postoperative time data are available to compare to the five-year review survey data.

Public Comments

30-Jun-95

Code: 36533

1995 RVUs: 3.82

Recommended RVUs: 5.70

Ratio:

Long Descriptor: Insertion of implantable venous access port, with or without subcutaneous reservoir

Reference Set (y/n): Y

Global Period: 010

Frequency: 82,115

Impact: 154376

Source: 2

Year: 92

Public Comment Letter: 346

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACS

Societies Wishing to Comment: APSA, SCVIR, SVS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
36533	31.7	5.4	18.6	56.9	13.8	3.8	9.6	10

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
36533	58879	88469	22.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
36533	68.2	65.5	-1.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
36533	general surgery	71.5
	group practices	3.2
	radiology	2.3
	thoracic surgery	7.7
	vascular surgery	6.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
36533	153	1	MALIGNANT NEOPLASM OF COLON
	162	1.4	MALIGNANT NEOPLASM OF TRACHEA, B

Public Comments

30-Jun-95

174	1.3	MALIGNANT NEOPLASM OF FEMALE BR
202	1.1	OTHER MALIGNANT NEOPLASMS OF LY
459	1.8	OTHER DISORDERS OF CIRCULATORY S
585	3.1	CHRONIC RENAL FAILURE
996	2	COMPLICATIONS PECULIAR TO CERTAI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
36533							
ACS			010		3.82		3.82

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
36533								
ACS	3.82	3.82		1.00	1.00	1.00	5.70	346

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
36533								
ACS	010							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
36533									
ACS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
36533									
ACS				5.70	3.82				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 36830 Global Period: 090 1995 RVW: 7.78 **Recommended RVW: 11.25**

CPT Descriptor: Creation of arteriovenous fistula by other than direct arteriovenous anastomosis; nonautogenous graft

Source and Summary of Comment to HCFA on this service: A technical Consulting Panel of 11 vascular surgeons designed a study to measure the major component of work for vascular surgical procedures by collecting and analyzing accurate intraoperative surgery time (skin-to-skin) of commonly performed vascular and non-vascular procedures. Data were collected from operative logs and computer databases at ten hospitals, both private and University. Median intra-Service time and intra-service work per minute (IWPUT) were calculated (Appendix I). The results of this study found the intra-service work of code 36830 to be significantly undervalued based on a comparison with typical "signature" procedures from many other surgical disciplines. This prompted a survey of code 36830 which was presented to the RUC Subcommittee Workgroup 4 in July. There was some concern that this procedure was one performed by general and transplant surgeons as well and that the survey might not be truly reflective of the views of those doing the procedure. A second survey was conducted including transplant and general surgeons. These data form the basis for this report.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old right handed patient with hypertension and insulin dependent diabetes has chronic renal failure. He has never had a previous hemoaccess procedure. Neither cephalic vein is an acceptable conduit for an A-V fistula access. As an out-patient he has a left arm A-V graft using PTFE inserted with local anesthesia and intravenous sedation (by an anesthesiologist). He returns for one visit for suture removal as an out-patient.

Description of Pre-Service work: Pre-service work begins after the decision to operate is made, from the day before the operation until the beginning of the procedure. This includes obtaining and reviewing pre-procedural work-up, with special attention to acid base and electrolyte values as well as cardiac and hematologic status; consulting with the referring physician and nephrologist and other health care professionals; and communicating with the patient and patient's family to review the operative risks, benefits, and alternative treatments, and to obtain informed consent. Additional pre-operative services include ensuring that the surgical instruments and supplies that might be necessary are available in the operative suite, scrubbing and supervision of the positioning, prepping, and draping of the patient. Appropriate lines are connected including electrocautery and suction tubes. Anesthesia is achieved with intravenous sedation and with local anesthesia prior to making the incision.

Description of Intra-Service work: An incision is made in the axilla and the basilic vein is isolated and encircled. A separate incision is made above the elbow and the brachial artery is likewise identified, mobilized and encircled. A suitable prosthetic graft is selected and a tunnel is created beneath the skin on the lateral portion of the arm. The graft is pulled through this tunnel and anastomosed to the basilic vein. The graft is trimmed to the appropriate length and anastomosed to the brachial artery in an end-of-graft to side-of-artery fashion. Once all bleeding is controlled and satisfactory flow into the vein is achieved, the two incisions are carefully closed in layers.

Description of Post-Service work: Post-service work begins after skin closure in the operating room and includes application of sterile bandages, checking the extremity for adequate arterial perfusion, and transfer of the patient to the recovery room where postoperative orders are written. Post-service work also includes stabilization of the patient in the recovery room and monitoring blood values. It also includes communication with the family and other health care professionals (including written and oral reports and orders). Discharge management includes the surgeon's final examination of the patient, discussion of the hospital and likely post hospital events, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure including removal of sutures, out-patient wound care, and antibiotic and pain medication adjustments. Finally, those these patients do not frequently see their surgeon in the global period, they are the cause of numerous phone conversations that are time consuming and often highly inconvenient (i.e., while the surgeon is in an operating room with another patient) with the patient who has not understood instructions because of infirmity or uremia, with the referring physician, with the referring nephrologist, and with the staff of the dialysis center where the patient is dialyzed.

SURVEY DATA:

Specialty: Society for Vascular Surgery (SVS) & Internatl. Society for Cardiovascular Surgery (ISCVS). Included also are general and transplant surgeons from around the country who are known to do hemoaccess procedures.

Sample Size: 72 Response Rate: 34 (47.2%) Median RVW: 11.81

25th percentile RVW: 10.5 75th Percentile RVW: 12 Low: 8.39 High: 19

Median Pre-Service Time: 55 Median Intra-Service time: 120

25th Percentile Intra-Svc Time: 105 75th Percentile Intra-Svc Time: 120 Low: 46 High: 180

Median Post-Service Time: Total Time Number of Visits

Day of Procedure	<u>25</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>0</u>	<u>0</u>
Office:	<u>20</u>	<u>1</u>

This is a new survey directed to those known to perform hemoaccess operations. At the request of the subcommittee, transplant surgeons and general surgeons were included in those surveyed in addition to vascular surgeons. The 34 respondents include 9 that categorized themselves as general surgeons, 13 who categorized themselves as vascular surgeons, and 12 as transplant surgeons. *It should be noted that many that view themselves as vascular surgeons are characterized in various registries as general surgeons thus accounting for the disparity frequently noted in Medicare data that suggest that general surgeons do most of the vascular surgery performed on Medicare patients. Reflecting this classification anomaly, the American College of Surgeons, which represents general surgeons for payment issues, has consistently deferred to the vascular surgical societies for RBRVS Comments.*

The vignette used in this survey was changed at the request of a subcommittee member to lower the severity of illness of the "typical patient". Twelve of the 34 (35%) respondents replied that the vignette did not describe their typical patient and all expressed the view that the typical patient is considerably sicker with many more comorbidities. This view that the typical vascular access patient is sicker than that described in the vignette is shared by the Vascular Society RUC Advisors.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	35661	Bypass graft, with other than vein, femoral-femoral	11.81
2)	36821	Arteriovenous anastomosis, direct, any site (eg, Cimino type)	8.39
3)	35650	Bypass graft, with other than vein, axillary-axillary	13.05
4)	50370	Removal of transplanted renal allograft	11.11

RELATIONSHIP OF CODE BEING SURVEYED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Comparison to 36821 (A-V Fistula with vein, eg, Cimino type): CPT code 36821 is probably the best comparison code for 36830 because the operations are done in similar patients for the same reasons. #6830 simply represents a more complex surgical procedure. The survey respondents believed that the pre and post service time spent for 36830 was the same as that required for 36821, the intra-service time was 40 minutes more than 36821, and the intensity was slightly more than that of 36821. Using the Workgroup 4 comments that valued one hour of intraoperative work at 4.80 RVUs the value of 36830, when compared with 36821 should be 11.58 ($0.667 \times 4.80 + 8.39$). This comparison, therefore, indicates that a work value for 36830 of 11.25 RVW is reasonable, using 36821 as a reference code.

Comparison to 35661 (Femoral-femoral bypass): Almost all survey respondents believed that the intra-service time spent for 36830 was about the same as that required for 35661, the total time was 30 minutes less than 35661, and the intensity was slightly less than that of 35661. This comparison, therefore, indicates that a work value for 36830 of 11.25 RVW is reasonable, using 35661 as a reference code.

RATIONALE:

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The recommended increase in RVW is based upon improvements in the accuracy of existing work, time, and intensity data for this code.

1. Work: The Harvard work value was originally estimated at 8.01 units by a panel without substantial participation by vascular surgeons (see Appendix III in previous submission for compelling evidence discussion). The work RVU was decreased to 7.78 in 1992 for budget neutrality purposes where it has remained. Since 36830 is clearly more complicated than 36821 (two vascular anastomoses rather than one, insertion and tunneling of a prosthetic graft, usually two incisions rather than one) yet is valued less

than 36821 (7.78 vs. 8.39), it is clear that code 36830 is misvalued. The value of 36821 was considered by the RUC in June 1993 and determined to be accurate. The extent of this misvaluation becomes even more apparent when it (code 36830; 7.78 work RVUs) is compared with two other similar vascular procedures: femoral-femoral bypass (code 35661; 11.81 work RVUs) and axillary-axillary bypass (code 35650; 13.05 work RVUs). Both of these comparison codes require two vascular anastomoses: insertion and tunneling of a prosthetic graft, not used in 36821; and two incisions. All three take about the same amount of time to perform. The primary difference is that chronic renal failure patients are sicker.

The median RVW of the current survey is 11.81 units (compared to 12 of the earlier survey). Comparison to one of the two key reference services (code 36821) indicates a value of 11.58 work units for 36830. Comparison to the other reference service (code 35661) indicates a value of about 11.0 work units for 36830. In addition, the work survey reported by the American College of Surgeons in their February 6, 1995 Comment to HCFA (Appendix VIII in that report) suggests a work value of 12.75 for this service.

2. Time: The Harvard intra-service time is 92 minutes, lower than that revealed in our survey of 120 minutes. The survey participants were asked to provide measured times rather than estimated. This figure is consistent with the earlier measured time of 115 minutes for intra-service work.

3. Intensity: The intensity of 36830 is moderate with a median mental effort/judgment of 3, a median technical skill value of 3 and median psychological stress value of 3. While intensity is difficult to compute back to work values, a commonly calculated figure is that of intra-service work per unit time, or IWPUT. The IWPUT for 36830 in 1995 is 0.041 based on our SVS 10 hospital data analysis of OR log times for procedures (Table 1 of previous submission) It is 0.052 according to the Summary of work and time estimates for services undergoing investigation (AMA RUC June 1, 1995). This is less than that accorded most other major procedures in all other specialties. If 36830 is recalculated using an IWPUT of 0.080 (Workgroup 4 notes) a more accurate reflection of intra-service intensity is achieved. By this technique, intra-work is 9.6. Pre- and post-service time in this survey was 100 min. Reimbursement for this time is calculated at 0.028 RVUs/min (Workgroup 4 notes). This adds an additional 2.8 work units for a total of 12.4. Even if a pre-service time of 30 minutes (25th percentile) is used, this would still give a value of 2.1 for pre- and post-service time and a total of 11.7.

Summary: Five different analyses suggest work values from 11.0 to 13.0 for this service:

1. Median Survey value is **11.81**.
2. The American College of Surgeons survey suggests a value of **12.75**.
3. Comparison to 35606 and 35661 by our survey respondents suggests a value of between 11 and **11.58**.
4. Using IWPUT figures, this analysis technique suggests a value of at least **11.7**.
5. The median survey among vascular surgeons submitted earlier to the RUC was **12.0**.

After careful review of both survey results, we recommend a value of **11.25** for 36830.

QUESTIONNAIRE

CPT Code Number: 36830

Global Period: 090

CPT Descriptor: Creation of arteriovenous fistula by other than direct arteriovenous anastomosis; autogenous graft

Typical Service/Patient: A 40 year old right handed patient with hypertension and insulin dependent diabetes has chronic renal failure. He has never had a previous hemoaccess procedure. Neither cephalic vein is an acceptable conduit for an A-V fistula access. As an out-patient he has a left arm A-V graft using PTFE inserted with local anesthesia and intravenous sedation (by an anesthesiologist). He returns for one visit for suture removal as an out-patient.

Step 1 Estimate the Relative Value of Physician Work (work RVU): _____

Step 2 List one or two important reference services (Table 1) in estimating physician work for this code (List only the CPT code numbers for the reference services):

1) _____ 2) _____

Step 3 Estimate the following service characteristics for the code that you have rated and your key reference services:

Service Characteristic	CPT code that you have rated in Step 1	Reference Service 1 (from Step 2)	Reference Service 2 (from Step 2)
CPT Code	36830		
TIME IN MINUTES (See Appendix A for detailed definitions of Time Periods)			
Pre-Service Time			
Intra-Service Time			
Post-Service Time:			
Day of Procedure			
ICU (Total Time/Number of Visits)	/	/	/
Other Hospital (Total Time/# of Visits)	/	/	/
Office (Total Time/Number of Visits)	/	/	/
Complexity/Intensity on a scale of 1 to 5 (1=least complex, 5=most complex) (See Appendix A for detailed definitions)			
Mental Effort and Judgment			
Technical Skill & Physical Effort			
Psychological Stress			

Step 4 Has the work of performing this service changed in the past 5 years? ___ Yes ___ No. If yes, complete a - c.

- a. This service represents new technology that has become more familiar (i.e., less work). ___ I agree ___ I do not agree
- b. Patients requiring this service are now: ___ more complex (more work) ___ less complex (less work) ___ no change
- c. The usual site-of-service has changed: ___ from outpatient to inpatient ___ from inpatient to outpatient ___ no change

Step 5 Do you agree that the Typical Service/Patient provided above describes your typical patient? Yes ___ No ___

Step 6 What percentage of your practice is devoted to vascular surgery (not counting hemoaccess procedures) _____%

Step 7 How would you characterize yourself: Transplant surgeon ___; General surgeon ___; Vascular surgeon ___

Step 8 Do you have the Special Certificate in Vascular from the American Board of Surgery? Yes ___; No ___

Table 1

Vascular Surgery

Society for Vascular Surgery/International Society for Cardiovascular Surgery

CPT Code	1995 Descriptor	Work RVU	Global Period
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	0.94	XXX
99254	Initial inpatient consultation for a new or established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	2.27	XXX
34201	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision	8.04	090
15100	Free skin graft; split graft, trunk, scalp, arms, legs, hands, and/of feet (except multiple digits); 100 sq cm or less, or each one percent of body area of infants and children (except 15050)	8.05	090
36821	Arteriovenous anastomosis, direct, any site (eg, Cimino type)	8.39	090
27880	Amputation, leg through tibia and fibula	10.69	090
50370	Removal of transplanted renal allograft	11.11	090
47605	Cholecystectomy with cholangiography	11.53	090
35661	Bypass graft, with other than vein, femoral-femoral	11.81	090
35650	Bypass graft, with other than vein, axillary-axillary	13.05	090
35558	Bypass graft, with other than vein, carotid-subclavian	17.40	090

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RUC guidelines for compelling evidence

The limitations of the work values assigned to vascular surgery codes can be related to the RUC guidelines published in May 1994 for developing compelling evidence to change RVWs. Five of these eight guidelines seem to pertain directly to the vascular surgery experience:

1. *Proof that incorrect assumptions were made in the initial valuation of the service, as documented, for example, by a misleading vignette in the Harvard study, data from the study, and flawed crosswalk assumptions.*

- We believe that incorrect assumptions were made in the initial valuation of many vascular services. For example, the vignette in the Harvard study of abdominal aortic aneurysm recounted a healthy 65 year old male with a five centimeter aneurysm. Most patients with abdominal aortic aneurysms (CPT codes 35081 and 35102) are older than 65, and virtually all have one or more comorbid conditions such as coronary artery disease, hypertension, or some compromise of kidney function.

2. *Proof that the mechanism or methodology used in the original valuation was seriously flawed, for example, evidence that no pediatricians were consulted in assigning pediatric values.*

- We believe the mechanism or methodology used in the original valuation was seriously flawed in that no vascular surgeons were on a Phase I, II, or III RBRVS technical consulting panel. In contrast, there were a total of eight dermatologists, eleven psychiatrists, seven plastic surgeons, etc.. Indeed, there were three "thoracic/cardiovascular" members in Phase I, none of whom was a vascular surgeon as defined as having vascular surgery as a primary focus of their practice or being an active member in our highly inclusive North American Chapter of the International Society for Cardiovascular Surgery. Vascular procedures were evaluated as a small part of a larger group of cardiac and general surgical procedures by cardiac surgeons or by general surgeons, few of whom did vascular procedures on a regular basis. (The instructions given by Hsiao were for the surgeon evaluators to give estimates of the time and intensity if the surgeon was familiar with the procedure, even if he or she didn't actually routinely perform the procedure.) Moreover, in Phase I-III only eleven of 220 vascular codes were surveyed by Hsiao and, of these eleven, only three represented arterial reconstructive procedures, the principal responsibility of vascular surgeons.

3. *If Harvard surveyed one specialty to obtain a value, but it turns out that that the service is now provided by physicians from a different specialty according to BMAD.*

- It is clear that Harvard surveyed general and cardiac surgery to obtain vascular values, but it turned out that that the surgeons chosen did not perform vascular surgery and consistently and markedly underestimated the work of vascular procedures as will be clearly apparent.

4. *An anomalous relationship between the coding being valued and multiple key reference services. For example, if code A describes a service that requires significantly more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for each of the four codes.*

- The rank order within vascular codes is appropriate because of our earlier work in 1991 and 1992 (on the basis of the Harvard study the vascular codes were originally markedly distorted). In contrast, when vascular procedures are compared to other specialty procedures requiring similar amounts of work, the vascular procedures are consistently undervalued. We have attempted herein to provide evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for each of the codes for which we are requesting increases in RVUs.

5. *Analysis of other data on time and effort measures, such as operating room logs.*

- The Council has attempted to obtain accurate time data, rather than estimates, for vascular surgery procedures. Table 1 provides data on intra-service time derived from accurate operating room logs, most often computer based, for a wide range of procedures. Data were collected from 10 hospitals across the country, and, for most procedures, involved a minimum of 300 procedures of each type.

Public Comments

30-Jun-95

Code: 36830

1995 RVUs: 7.78

Recommended RVUs: 12.75

Ratio:

Long Descriptor: Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft

Reference Set (y/n): N Global Period: 090 Frequency: 45,823 Impact: 227740

Source: 1 Year: 92 Public Comment Letter: 337

Reference Services:

CMD Comment:

--

Societies Wishing to Survey: SVS

Societies Wishing to Comment: ACS, APSA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
36830	27.3	4	43.6	54.2	7.1	15.9	42.2	6.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
36830	45910	50375	4.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
36830	82.5	77.2	-2.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
36830	cardiac surgery	2.2
	general surgery	59.5
	group practices	2.9
	thoracic surgery	13.7
	vascular surgery	16.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
36830	585	17.7	CHRONIC RENAL FAILURE

Public Comments

30-Jun-95

586	2.7	RENAL FAILURE, UNSPECIFIED
996	6.7	COMPLICATIONS PECULIAR TO CERTAI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfewk95	Ratio5h	Mfewk92
36830							
SVS		090	090	8.01	7.78	0.97	7.78

Harvard Data:

Comm	Mewk93	Mfewk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
36830								
SVS	7.78	7.78	0.97	1.00	1.00	1.00	12.75	337

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
36830								
SVS	090	8.01		22		92		39

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
36830									
SVS		1.0		10	4.0		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfewk95	Sp	Phase	Twput	lwput
36830									
SVS		10		12.75	7.78	gs	n		0.052

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

General Surgery, Colon and Rectal Surgery, and Gastroenterology

Review of general surgery procedures primarily addressed comments submitted by the American College of Surgeons (ACS) on codes identified as misvalued through a study conducted by Abt Associates Inc. Although this study identified many procedures as potentially misvalued, the ACS comments selected only 30 codes for review, based on the magnitude of the change and their frequency and expenditures. The ACS recommended both increases and decreases. The RUC recommends adoption of most of the recommended decreases and a few of the recommended increases, based on results from a survey of 175 surgeons, comparisons to the final Harvard study results, comparisons to key reference services, and analysis of Medicare claims data.

The American Society of General Surgeons (ASGS) also submitted comments on a number of procedures, including several general surgery procedures, and their suggestions were consistent with some of those made by the ACS. The current RVUs for several of the codes identified by the ASGS, however, are based on previous RUC recommendations, and the RUC did not believe reconsideration was warranted.

The American Society of Colon and Rectal Surgeons (ASCRS) submitted comments indicating that the partial colectomy codes and hemorrhoidectomy codes should be reviewed to place them in a more correct rank order from least to most difficult. The CMDs identified rank order problems in these families as well, and also identified three overvalued procedures, and the ASGS commented that the RVUs for several colon and rectal procedures services should be increased. The RUC agreed with most of the recommended changes based on the evidence provided by the ASCRS.

Comments were submitted by the American College of Gastroenterology (ACG) and a CMD on several gastroenterology codes. The RUC did not believe compelling evidence had been provided to either increase or decrease the RVUs for these services, since most gastroenterology procedures have previously been reviewed by the RUC.

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
General Surgery						
21930	Remove lesion, back or flank	6.55	4.82	This code was identified as overvalued in the ACS Abt study and a reduction to 4.82 RVUs was recommended. The procedure was considered overvalued in comparison to codes 54520 [<i>simple orchiectomy</i>] and 63688 [<i>Revision or removal of implanted spinal neurostimulator pulse generator or receiver</i>].	The RUC accepted the recommended reduction.	3
22900	Remove abdominal wall lesion	6.56	5.13	This code was identified as overvalued in the ACS Abt study. It is considered comparable to codes 39400 [<i>Mediastinoscopy, with or without biopsy</i>] and 54520 [<i>simple orchiectomy</i>].	The RUC accepted the recommended reduction.	3
43420	Repair esophagus opening	10.19	10.19	The ASGS recommended an increase to 11.89 RVUs.	Since there are fewer than 1,000 claims annually, the RUC did not believe a survey of practicing physicians would yield sufficient evidence to support the change. No one provided other evidence, and the RUC recommends the current RVUs be maintained.	2
43610	Excision of stomach lesion	10.11	10.11	The ASGS recommended an increase to 15.57 RVUs.	The current RVUs are based on a previous RUC recommendation, and no evidence was provided by the ASGS to warrant reconsideration. The RUC recommends maintaining the current RVUs.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
43750	Place gastrostomy tube	5.71	4.27	Although an increase had been recommended for 43750 in the original comment, the ASGS indicated that it had misunderstood that 43750 is for percutaneous endoscopic gastrostomy (PEG) and 43830 is for the more complex tube placement. The ASGS and ACS agreed, therefore, that an anomaly exists in the current RVUs with 43750 valued higher than 43830.	Harvard data indicate that the intrawork per unit time (IWPUT) for 43750 is 0.082, while it is 0.059 for 43830. Since 43830 is much more complex than 43750, the IWPUT is the reverse of the appropriate relationship. Code 43830 is often done for pediatric patients and for brain-injured patients. It was valued by Harvard at 6.52 RVUs, which is 35% higher than the current Medicare RVUs. Even at the higher Harvard RVUs, however, the IWPUT is too low. The RUC recommends adopting the ACS recommended increase for 43830 from 4.84 to 7.50 RVUs, but also decreasing 43750 from 5.71 to the Harvard RVUs of 4.27. It considered calculating frequency-weighted RVUs for the two services, but because it is often done for pediatric patients, it did not seem appropriate to base the RVUs on Medicare frequencies.	5
43830	Place gastrostomy tube	4.84	7.50			1
44950	Appendectomy	6.06	6.06	The ACS recommended increasing both these services to 8.25 RVUs.	The ACS argued that the RVUs for appendectomy should be increased because the services involve more time than is assumed in the current value and that the services are more complex because patients seek care later. The current RVUs are based on the Harvard study, however, and the RUC did not believe sufficient evidence was presented either that the Harvard study of this service was fatally flawed or that the service has changed since that time to justify increasing the RVUs.	2
56315	Laparoscopic appendectomy	6.06	6.06			2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
47130	Partial removal of liver	31.56	31.56	The ASGS recommended an increase to 32.16.	Since there are fewer than 1,000 claims annually, the RUC did not believe a survey of practicing physicians would yield sufficient evidence to support the change. No other evidence was provided, and the RUC recommends the current RVUs be maintained.	2
47600	Removal of gallbladder	10.68	10.68	The ACS originally recommended increases in all five of these cholecystectomy services based on its Abt study, but withdrew the recommended increases for 47600 and 47605, and the corresponding laparoscopic codes 56340 and 56341 when RUC survey data did not support the increases.	In the absence of any data to suggest an increase, the RUC recommends that the current RVUs for 47600, 47605, 56315, and 56340 be maintained.	2
47605	Removal of gallbladder	11.53	11.53		The RUC recommends increasing 47610 [<i>Cholecystectomy with exploration of common duct;</i>] from 13.86 to 15.00 RVUs because the use of ERCP has removed the simpler patients from this service and made the typical patient more complex, and to achieve a better relationship between 47610 and 47605, which has 11.53 RVUs and does not involve exploration of the common duct. In addition, the RUC evaluated the comparative work of code 50080 for ureteroenterostomy, direct anastomosis of ureter to intestine (13.10 RVUs), and, particularly, code 44140 for partial colectomy (16.97 RVUs). Patients undergoing 47610 are likely to be sicker than patients undergoing 44140, they are jaundiced, the procedure is more urgent, and the obstructed liver presents problems and adds to the procedure's complexity. In addition, many of these procedures are reoperations.	2
47610	Removal of gallbladder	13.86	15.00		1	
56340	Laparoscopic cholecystectomy	10.68	10.68		2	
56341	Laparoscopic cholecystectomy	11.53	11.53		2	

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
48150	Partial removal of pancreas	40.25	40.25	The ASGS submitted a comment that the RVUs for the Whipple procedure should be decreased by 0.06 RVUs to 40.19.	The current RVUs for this service are based on a previous RUC recommendation and review by a HCFA refinement panel. The RUC did not believe reconsideration was warranted, particularly given the extremely slight magnitude of the suggested change.	2
49000	Exploration of abdomen	8.99	11.00	The ACS commented that the code is comparable to codes 51860 [<i>simple cystorrhaphy</i>] and 52601 [<i>TURP</i>]. Although the service may be provided to either trauma or non-trauma patients, the non-trauma patients tend to be more complex, and the trauma patients require "exclusionary" laparotomy.	The RUC accepted the specialty's recommendation that the RVUs for exploratory laparotomy be increased. The service has become more complex over time due to changes in the patient population that are in turn due to the use of diagnostic laparoscopy and CT scans. The RUC compared the service to codes 51860 [Repair of bladder wound, 11.17 RVUs] and 52601 [Prostatectomy (TURP), 11.51 RVUs] from the MPC, as well as code 38115 [Splenorhaphy, 12.59 RVUs] and agreed the recommended increase was justified.	1
49180	Biopsy, abdominal mass	1.49	1.73	The SCVIR recommended that code 49180 for percutaneous needle biopsy of abdominal mass be increased to the median value of other biopsy services such as percutaneous needle biopsies of the liver (code 47000, 1.90 RVUs), lung (code 32405, 1.93 RVUs), and kidney (code 50200, 2.63 RVUs).	The RUC agreed in principal that the RVUs should be more equivalent for these services. The SCVIR did not provide survey data supporting its recommended value of 1.93, however, so the RUC based its recommendation of 1.73 on the Harvard RBRVS study.	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
49255	Removal of omentum	4.04	10.25	The ACS commented that the work for this code is equivalent to 23412 [<i>repair of ruptured musculotendinous cuff</i>]. In addition, it is similar in intensity and length of stay to code 62223 [<i>creation of ventriculo-peritoneal or pleural shunt</i>]. More postoperative work is involved in the omentectomy, however, since a malignancy is involved and follow-up care such as chemotherapy needs to be determined.	At 4.04, the current RVUs for code 49255 for omentectomy are 60% lower than the Harvard RVUs of 10.25 for this service. The ACS recommended 11.50 RVUs based on the time involved in the procedure and comparison to codes such as 58950 for oophorectomy, with 6.54 RVUs, and 49002 for reopening of recent laparotomy, which, at 9.40 RVUs, involves less work than 49255. Code 49255 involves the same procedure as 49002, but also involves the additional work of an omentectomy and lysis of adhesions. Because the ACS surveyed times were so close to the Harvard times, however, the RUC recommends adoption of the Harvard RVUs of 10.25.	4
49505	Repair inguinal hernia	6.17	6.17	The ASGS commented that the RVUs for 49505 should be increased to 8.66.	This family of codes has already undergone substantial review by the RUC and HCFA refinement panels. No evidence was presented that the work of the service has changed since the most recent review and the RUC recommends the current RVUs be maintained.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
49900	Repair of abdominal wall	4.54	9.40	The ACS commented that 49900 is at least as much work as code 23412 [<i>Repair of ruptured musculotendinous cuff (eg, rotator cuff); chronic</i>] and 62223 [<i>creation of ventriculo-peritoneal shunt</i>]. Code 44900 compares favorably with the intensity of the intraoperative work, along with a longer hospital stay and more difficult postoperative management due to prolonged naso-gastric suction and ileus associated with it.	The RUC compared code 49900 for suture of abdominal wall for evisceration or dehiscence to code 49002 for reopening of a recent laparotomy (9.40 RVUs). Both codes involve reoperations, but 49002 is planned whereas 49900 is an urgent procedure done for patients who are immunocompromised, malnourished, and critically ill. In addition, they are sicker at the time of the reoperation than the first operation. The ACS survey showed that the service involved considerably more time, particularly postservice time, than the Harvard study, and that it involved three ICU visits compared to none in the Harvard study. This service was not directly surveyed by Harvard, and the RUC concluded that the Harvard data were flawed. Claims data such as the percent of beneficiaries who are disabled and older lends further support to the RUC's recommendation that 49900 be increased from 4.54 to 9.00 RVUs.	1
56312	Laparoscopic lymphadenectomy	12.06	12.06	A clinic identified this service as undervalued.	The current RVUs are based on a RUC recommendation. The RUC did not believe reconsideration was warranted and recommends the current RVUs be maintained.	2
56360	Peritoneoscopy	4.04	3.87	The ACS recommended a reduction based on its Abt study.	The RUC agrees with the recommended reduction.	3

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
Colon and Rectal Surgery						
44010	Incision of small bowel	9.24	9.24	A CMD recommended an increase to 10.05 RVUs for 44010 and a decrease to 9.95 RVUs for 44020, stating that intensity of 44010 is higher because if the duodenotomy leaks post-op, it is usually more catastrophic than if an enterotomy leaks. Also, operative access to duodenum takes more time than access to jejunum and ileum.	Since there are fewer than 1,000 claims annually, the RUC did not believe a survey of practicing physicians would yield sufficient evidence to support the changes, and recommends the current RVUs be maintained.	2
44020	Exploration of small bowel	10.69	10.69			2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
44140	Partial removal of colon	16.97	16.97	<p>The ASCRS submitted a comment indicating that the partial colectomy codes, 44140 through 44145 should be reviewed to place them in a more correct rank order from least to most difficult. The CMDs also identified rank order problems in these codes.</p>	<p>The ASCRS conducted a survey of the work involved in these codes. It recommended and the RUC agreed that the current RVUs for this family of codes are not in the correct rank order, and that the current RVUs for code 44140 and 44145, the elective procedures, should be retained.</p>	2
44141	Partial removal of colon	17.36	17.36			2
44143	Partial removal of colon	15.00	17.36			4
44144	Partial removal of colon	15.00	16.97			4
44145	Partial removal of colon	21.29	21.29			2

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
44152	Removal of colon/ileostomy	22.98	22.98	The ASGS commented that the RVUs for code 44152 should be increased from 22.98 to 25.21 RVUs.	The current RVUs for code 44152 were established by a HCFA refinement panel and the RUC did not consider the evidence presented by ASGS sufficiently compelling to warrant changing the current RVUs.	2
44160	Removal of colon	14.09	14.09	Comments suggested the RVUs for code 44160 should be increased from 14.09 to 14.52.	No further evidence was presented to support the comments on code 44160, so the RUC recommends retaining the current RVUs.	2
44322	Colostomy with biopsies	10.31	10.31	A CMD commented that 44322 should be increased to 11.70, which would be higher than 44320, a colostomy without biopsies valued at 11.39. This recommendation would correct a rank order anomaly by adding 0.31 RVUs to 44320. A colonoscopy without biopsy (code 45378) has 3.70 RVUs. A colonoscopy with biopsies (code 45380) has 4.01 RVUs. The addition of biopsies to the basic procedure is therefore 0.31 RVUs (4.01 - 3.70).	Since there are fewer than 1,000 claims annually, the RUC did not believe a survey of practicing physicians would yield sufficient evidence to support the changes, and recommends the current RVUs be maintained.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
44388	Colon endoscopy	2.82	2.82	An individual commented that the RVUs for all of these codes should be increased by more than 20%.	The RUC has previously reviewed the RVUs for these services and recommends the current RVUs be maintained.	2
44389	Colonoscopy with biopsy	3.13	3.13			2
44390	Colonoscopy for foreign body	3.83	3.83			2
44391	Colonoscopy for bleeding	4.32	4.32			2
44392	Colonoscopy & polypectomy	3.82	3.82			2
44393	Colonoscopy, lesion removal	4.84	4.84			2
44394	Colonoscopy w/ snare	4.43	4.43			2
45110	Removal of rectum	21.68	21.68	The ASGS commented that the RVUs for code 45110 should be increased from 21.68 to 28.78.	No further evidence was presented to support the comments on code 45110, so the RUC recommends retaining the current RVUs.	2
45303	Proctosigmoidoscopy	0.50	0.80	A CMD commented that code 45303 [<i>Proctosigmoidoscopy, rigid; with dilation, any method</i>] should be increased from 0.50 to 0.80 RVUs to value it more appropriately relative to 45300 [<i>Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</i>].	An ASCRS survey of the work involved in code 45303, as well as an explanation of what is involved in rigid proctosigmoidoscopy supported the recommended increase.	1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
45378	Diagnostic colonoscopy	3.70	3.70	The ACG submitted a comment that the RVUs for these services should be increased by about a third.	The RUC has previously reviewed these services. In addition, none of the specialties on the RUC Advisory Committee elected to conduct a survey or present any evidence supporting this suggested increase.	2
45380	Colonoscopy and biopsy	4.01	4.01			2
45550	Repair rectum; remove sigmoid	13.38	16.97	A CMD commented that this service involves 10% more work than 44140 [<i>Colectomy, partial; with anastomosis, 16.97 RVUs</i>].	An ASCRS survey of the work involved in code 45550 indicated it is currently undervalued, but found that the work is equal to 44140, not 10% more than 44140 as stated in the CMD comment.	1
46040	Incision of rectal abscess	4.90	4.41	A CMD commented that the value should be closer to 46045 [<i>Incision and drainage of intramural, intramuscular or submucosal abscess, transanal, under anesthesia</i>] and farther from 46060 [<i>Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton</i>].	The RUC agreed with the recommended reduction.	3
46255	Hemorrhoidectomy	4.95	4.95	The ASCRS commented that four hemorrhoidectomy codes, 46255, 46260, 46261, and 46262, should be reviewed to place them in a more correct rank order from least to most difficult. The ASGS also commented that the RVUs for several of these services should be increased. The CMDs identified rank order problems also, with 46261 and 46262 having more intraservice time than 46260.	Although a survey was conducted of the hemorrhoidectomy codes, the ASCRS recommended and the RUC agreed that the existing incremental RVU changes for codes 46255 [<i>Hemorrhoidectomy, internal and external, simple, 4.95 RVUs</i>], 46257 [<i>with fissurectomy, 5.87 RVUs</i>], and 46258 [<i>with fistulectomy, with or without fissurectomy, 6.26 RVUs</i>] provide a better basis for valuing codes 46260 through 46262 ["simple" is replaced by "complex or extensive" in these codes] than use of the survey medians. The RUC recommends, therefore, that the current RVUs be maintained for 46255 and 46260 and that 46261 and 46262 be increased.	2
46260	Hemorrhoidectomy	6.70	6.70			2
46261	Remove hemorrhoids & fissure	6.54	7.62			1
46262	Remove hemorrhoids & fistula	6.77	8.01			1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
46945	Ligation of hemorrhoids	3.06	1.90	A CMD commented that codes 46945 and 46946 for ligation of internal hemorrhoids are valued too high relative to hemorrhoidectomy by simple ligature (code 46221, 1.38 RVUs), which the Harvard study valued as equivalent to 46945.	The specialty society and the RUC agree with the recommended reductions.	3
46946	Ligation of hemorrhoids	4.04	2.76			3
47425	Incision of bile duct	14.79	NA	A CMD noted that, in 1994, RUC recommended and HCFA agreed to a value of 15.31 for code 47420, choledochostomy without sphincterotomy. This created a rank order anomaly with code 47425, choledochostomy <u>with</u> sphincterotomy. To determine an appropriate increment for sphincterotomy, the CMDs looked to the relationship of ERCP without sphincterotomy (code 93262, RVU 5.96) and ERCP with sphincterotomy (code 43262, RVU 7.39). The difference in RVUs (7.39-5.96) equals 1.43. This value was added to the value of 47420 to obtain the recommended RVU of 16.74 for 47425.	Based on inaccurate information, the RUC adopted as part of a "consent calendar" the recommended decrease to 13.50 RVUs that was noted in the "Summary of CMD Comments" table provided by HCFA, since no specialty society objected or asked to provide more evidence. Closer review of the actual CMD rationale, however, suggests the CMD was actually recommending an <u>increase</u> , not the decrease presented in the table. The error was not noted in time for the RUC to take any definitive action, so the RUC is not making any recommendation on this code.	NA
Gastroenterology						
43235	Upper GI endoscopy, diagnosis	2.39	2.39	The ACG and the ASGS submitted comments recommending that code 43235 be increased to 3.85 or 4.23 RVUs.	The RVUs for code 43235 are based on a previous RUC recommendation. Since no additional evidence was submitted by the commenting specialty societies, the RUC recommends that the current RVUs be maintained.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
43239	Upper GI endoscopy, biopsy	2.69	2.69	The ACG submitted a comment that the RVUs for these services should be increased from 34-54%.	The RUC has previously reviewed these services. In addition, none of the specialties on the RUC Advisory Committee elected to conduct a survey or present any evidence supporting this suggested increase.	2
43260	Endoscopy, bile duct/pancreas	5.96	5.96			2
43262	Endoscopy, bile duct/pancreas	7.39	7.39			2
43456	Dilate esophagus	3.52	2.57	A CMD recommended this decrease because the current value represents more than 50% greater intensity than 43458 [Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia], which is a slighter longer and equally difficult procedure. Revised value gives 43456 the same intensity as 43458.	The RUC agrees with the recommended decrease.	3

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key
91122	Anorectal manometry	1.77	1.77	The CMDs submitted a comment that code 91122 should be decreased from 1.77 to 0.66 RVUs because anorectal manometry is less work than 99204 [Office/outpatient visit, new, 1.71 RVUs] and is similar to the combination of 46600 [Diagnostic anoscopy, 0.50 RVUs] and 93770 [Measure venous pressure, 0.16 RVUs].	The American Society for Gastrointestinal Endoscopy (ASGE) conducted a survey of the work involved in anorectal manometry which produced a 1.81 median value. The specialty explained that diagnostic anoscopy is a simple, straightforward procedure which takes only a few minutes. With 30 minutes of intraservice time and 65 minutes for the complete procedure, however, anorectal manometry is a much more complex service. The physician must perform a digital rectal exam, insert a multichannel catheter into the rectum 15-20 cm., and perform station pull-through at half-cm increments to identify the location of the internal anal sphincter and basal pressure. This process must be repeated four times, with the patient squeezing as hard and long as possible to determine maximal squeeze pressure and duration. Then, the physician must test sensation with pinprick in 4 anal quadrants, measure baseline pressure for 5 minutes, then gradually inflate and deflate a balloon to and from various cc's to determine sensing threshold. Finally, the physician must analyze the tracing, calculate pressures, and explain initial impressions to the patient. The service cannot be provided by a technician and it involves a repeated process of testing and evaluation, not a single pressure measurement. In time and complexity, it is comparable to 99204. The RUC recommends that the current RVUs be maintained.	2

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**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 43830 **Global Period:** 090 **1995 RVW:** 4.84 **Recommended RVW:** 7.50

CPT Descriptor: Gastrostomy, temporary (tube, rubber or plastic) (separate procedure);

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 14 general surgeons, with the assistance of Abt Associates, Inc., designed a study that included a survey instrument to effectively measure all aspects of physician work for commonly performed general surgery services. The results of this study found code 43830 to be undervalued at the present time.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

19-year-old male, who attempted suicide by ingesting lye, developed a severe esophageal stricture and now requires long-term alimentation through a gastrostomy tube. He was taken to the operating room and underwent insertion of the tube. Postoperatively, he did well and was discharged on the fourth postoperative day, to be followed in the office.

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made until the time of the procedure. This activity includes obtaining and reviewing previous laboratory and imaging studies, with special attention to cardiopulmonary and hematologic status; consulting with the referring physician, if necessary, and with other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work:

The abdomen is opened, and the epigastrium is assessed for the presence of any contraindications to gastrostomy tube placement. An appropriate site for tube placement is selected on the anterior gastric wall, and a double purse-string suture is placed at that site. A separate skin incision site for tube exit through the anterior abdominal wall is selected, and a tunnel is created through the anterior abdominal wall to connect the exit site to the site of the purse-string suture. A tube of the appropriate size is selected and introduced through the tunnel to the gastrostomy site. A gastrotomy is made within the purse-string suture, and the tube is advanced through the gastrotomy to the appropriate location within the stomach. The purse-string suture is tied down, creating a serosal-lined tunnel around the tube. The tube-bearing area of the stomach is then secured to the peritoneum of the anterior abdominal wall at the site of the anterior abdominal wall tunnel. The abdomen is closed in layers. The tube is secured to the skin of the anterior abdominal wall and is flushed to confirm patency. Sterile dressings are applied at the laparotomy and skin exit sites.

Description of Post-Service Work:

Post-service work begins after skin closure in the operating room and includes the application of sterile dressings at the laparotomy and skin exit sites. Post-service work also includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including careful monitoring of cardiopulmonary status; ordering and reviewing postoperative chest radiographs and laboratory studies; monitoring and care of the incisions and the functioning of the gastrostomy tube; instituting nutritional support; and antibiotic and pain medication management. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure, including removal of sutures; ordering and evaluating periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American College of Surgeons

Sample Size: 175

Response Rate (%): 56 (32%)

	Median	Low	25th pctl	75th pctl	High
RVW:	7.50	4.00	6.20	9.00	11.43
PRE-Service	30				
INTRA-Service	60	15	45	60	90
POST-Service:					
Day of procedure - total time	20				
ICU - total time / # of visits	0	0			
Other hosp. - total time / # of visits	45	4			
Office - total time / # of visits	25	2			

KEY REFERENCE SERVICE(S):

1995

RVW	Global	CPT	Descriptor
7.77	090	44300	Enterostomy or cecostomy, tube (eg, for decompression or feeding) (separate procedure)
5.71	010	43750	Percutaneous placement of gastrostomy tube
5.59	000	50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Slightly less work is required for 43830 than for 44300 due to the fact that it takes a bit longer to ascertain the exact position for placement of the tube in the jejunum. However, 43830 is considerably more work than 43750 or 50392, in that 43830 requires general anesthesia and limited laparotomy with subsequent closure, in addition to placement of the gastrostomy tube (43750) and its suture fixation to the intra-abdominal wall. Additionally, these patients require a hospital stay of 3-4 days. 43830 has a global period of 90 days, compared with 43750 and 50392, which are outpatient procedures and have global periods of 10 and 0 days, respectively.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Some of the patients who require this procedure have sustained neurological injuries, esophageal obstructions, gastroesophageal obstructions, or chronic debilitation and require long-term nutritional support. Many of these patients are not candidates for percutaneous endoscopic gastrostomy (PEG) or long-term nasogastric tube feeding. According to Medicare data, 92.2 percent of patients requiring this service are age 75 or older. Pediatric patients with repeated aspiration pneumonias secondary to gastroesophageal reflux also may require this service. The response to survey question 4b indicated that patients requiring this service are medically "more complex (more work)," which may relate, among other things, to the fact that patients often are either quite elderly or extremely young.

Code 43830 involves suturing the tube into position and then suturing the stomach to the abdominal wall. This action assures that, if the tube is dislodged, there is no spillage of the gastric contents into the peritoneal cavity, which could result in peritonitis. The PEG does not involve fixation of the stomach to the abdominal wall. Therefore, the tube may become dislodged and spillage of the gastric contents into the peritoneal cavity can occur.

Code 43830 was surveyed as part of the Harvard project. The work value that was recommended for this service was 6.52, which is considerably higher than the current work value of 4.84. Moreover, the value of 6.52 was based on an intra-service time of 51 minutes, which is less than the time of 60 minutes that was reported in the five-year review survey.

Public Comments

Code: 43830

1995 RVUs: 4.84

Recommended RVUs: 7.50

Ratio:

Long Descriptor: Gastrostomy, temporary (tube, rubber or plastic) (separate procedure);

Reference Set (y/n): N

Global Period: 090

Frequency: 18,959

Impact: 50431

Source: 2

Year: 92

Public Comment Letter: 346

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAP, ACS

Societies Wishing to Comment: ACEP, AOA, APSA, ASIM, SCVIR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
43830	63.5	28.7	18.3	56.9	6.5	0	1.3	15.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
43830	24897	21555	-7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
43830	90.8	91.4	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
43830	gastroenterology	7
	general surgery	77.9
	group practices	2.7
	thoracic surgery	2.8
	vascular surgery	2.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
43830	153	1.3	MALIGNANT NEOPLASM OF COLON
	263	4.1	OTHER AND UNSPECIFIED PROTEIN-CAL

Public Comments

30-Jun-95

276	1.2	DISORDERS OF FLUID, ELECTROLYTE, A
436	1.5	ACUTE, BUT ILL-DEFINED, CEREBROVAS
560	2.5	INTESTINAL OBSTRUCTION WITHOUT M
783	2.3	SYMPTOMS CONCERNING NUTRITION,
787	4.6	SYMPTOMS INVOLVING DIGESTIVE SYS
789	1.2	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
43830							
ACS		090	090	6.52	4.84	0.74	4.84

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
43830								
ACS	4.84	4.84	0.74	1.00	1.00	1.00	7.50	346

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	hime	Notett	Imppt
43830								
ACS	090	6.52		23		51		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
43830									
ACS		1.0		10	5.0		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
43830									
ACS		10		7.50	4.84	gs	n		0.059

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 47610 **Global Period:** 090 **1995 RVW:** 13.86 **Recommended RVW:** 15.00

CPT Descriptor: Cholecystectomy with exploration of common duct;

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 14 general surgeons, with the assistance of Abt Associates, Inc., designed a study that included a survey instrument to effectively measure all aspects of physician work for commonly performed general surgery services. The results of this study found code 47610 to be undervalued at the present time.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

55-year-old male presents with jaundice, a history of fatty food intolerance, and a past history of ultrasound-proven cholelithiasis. He underwent HIDA scan, which showed no filling of the gallbladder and no flow of the isotope into the intestines. Preoperatively, the ERCP revealed multiple filling defects in the common bile duct and multiple stones in the gallbladder. He was taken to the operating room and underwent cholecystectomy of the common duct, exploration with removal of four common duct stones consistent with the preoperative ERCP, and drainage of his common bile duct. Postoperatively, he did well and was discharged on the sixth postoperative day.

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the time of the procedure. This activity includes obtaining and reviewing previous laboratory and imaging studies, with special attention to cardiopulmonary, gastrointestinal, and hematologic status; reviewing findings at ERCP; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work:

The abdomen is incised, with dissection carried through the abdominal wall and into the peritoneal cavity. The peritoneum is explored for other abnormalities, and adhesions are taken down, as needed. The gallbladder is mobilized and a cholecystectomy is performed. The common bile duct is explored by mobilizing the duodenum (Kocher maneuver), opening the common bile duct, and removing any free stones and debris with irrigation, bile duct forceps, and biliary duct balloon catheters. The size and patency of the ampulla is assessed by passage of a biliary duct balloon catheter or a Bakes dilator. When all stones and debris are removed, a T-tube is selected, cut to fit the common bile duct, and placed in the duct to allow adequate drainage. The common bile duct is then repaired. The T-tube is sewn in place, brought out through a separate incision, and attached to a drainage device. A completion T-tube cholangiogram is then obtained to evaluate the patency of the ampulla, placement of the tube, and to exclude any retained common bile duct stones. The cholangiogram is interpreted in the operating room by the surgeon, and communication with the radiologist is undertaken, as indicated. Drains are inserted, as necessary. The abdominal wall is closed in layers, and dressings are applied.

Description of Post-Service Work:

Post-service work begins after skin closure in the operating room and includes the application of sterile dressings. Post-service work also includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon; careful monitoring of cardiopulmonary

status; ordering and reviewing postoperative radiographs and laboratory studies; monitoring and care of the incision; monitoring, maintenance, and removal of all drains; ordering and reviewing a T-tube cholangiogram, when indicated; and antibiotic and pain medication management. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the operation are considered part of the postoperative work for this procedure, including removal of sutures; ordering and evaluating periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American College of Surgeons

Sample Size: 175

Response Rate (%): 51 (29%)

	Median	Low	25th pctl	75th pctl	High
RVW:	15.00	11.50	13.55	15.58	18.00
PRE-Service	45				
INTRA-Service	120	50	113	150	230
POST-Service:					
Day of procedure - total time	30				
ICU - total time / # of visits	0	0			
Other hosp. - total time / # of visits	75	6			
Office - total time / # of visits	45	3			

KEY REFERENCE SERVICE(S):

1995

RVW	Global	CPT	Descriptor
8.90	000	43264	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of stone(s) from biliary and/or pancreatic ducts

11.53	090	47605	Cholecystectomy; with cholangiography
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RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The recommendation for the increased RVW for this service is based on the building block methodology. Code 47610 involves a cholecystectomy with cholangiography (code 47605, valued at 11.53) and an ERCP (code 43264, valued at 8.90). For purposes of recommending a value for code 47610, the portion involving the ERCP is valued at 50 percent or 4.45 (intra-operative time only). Based on the building block method ($11.53 + 4.45 = 15.98$), the value that is recommended for code 47610 is 15.00. This method, previously used and accepted by the RUC, demonstrates that this service is undervalued.

Public Comments

30-Jun-95

Code: 47610

1995 RVUs: 13.86

Recommended RVUs: 15.12

Ratio:

Long Descriptor: Cholecystectomy with exploration of common duct;

Reference Set (y/n): N

Global Period: 090

Frequency: 11,622

Impact: 14644

Source: 5

Year: 93

Public Comment Letter: 346

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACS

Societies Wishing to Comment: APSA, ASDM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
47610	59.9	20.2	8.9	62.7	3.4	0.6	0.6	18.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
47610	18049	13072	-14.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
47610	97.1	97.2	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
47610	general surgery	90.5
	group practices	2.1
	thoracic surgery	2.6
	vascular surgery	2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
47610	574	24.6	CHOLELITHIASIS
	575	4.9	OTHER DISORDERS OF GALLBLADDER
	576	3.4	OTHER DISORDERS OF BILIARY TRACT

Public Comments

30-Jun-95

577	1.8	DISEASES OF PANCREAS
782	1.4	SYMPTOMS INVOLVING SKIN AND OTHE
789	2.3	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
47610							
ACS		090	090	12.46	13.86	1.11	12.77

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
47610								
ACS	13.86	13.86	1.02	1.09	1.00	1.00	15.12	346

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
47610								
ACS	090	12.46		31		115		51

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
47610									
ACS		1.0		10	4.5		10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
47610									
ACS		10		15.12	13.86	gs	3		0.071

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 49000 **Global Period:** 090 **1995 RVW:** 8.99 **Recommended RVW:** 11.00

CPT Descriptor: Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 14 general surgeons, with the assistance of Abt Associates, Inc., designed a study that included a survey instrument to effectively measure all aspects of physician work for commonly performed general surgery services. The results of this study found code 49000 to be undervalued at the present time.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

19-year-old male presents to the emergency department with a stab wound of the left flank. Abdominal X-rays reveal no free air. He is hemodynamically stable. He subsequently develops abdominal tenderness over six hours of observation. The attack weapon was allegedly a butcher knife that is 12 inches long. CT scan reveals fluid in the cul-de-sac. He is taken to the operating room, where a thorough exploration reveals a stab wound of the left retroperitoneum with minimal bleeding. All other structures are normal. The incision is closed. The patient has an uneventful postoperative course and is discharged on the third postoperative day.

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made. This activity includes assessing the patient in the emergency department; taking a history regarding the incident; obtaining and reviewing emergency department admission imaging and laboratory studies, with special attention to cardiopulmonary, gastrointestinal, and hematologic status; communicating with other health care professionals; ordering preoperative antibiotics and tetanus prophylaxis; and arranging for an adequate supply of intra-operative blood products. Pre-service work, which is frequently performed under adverse circumstances due to uncooperative patients (secondary to drug or alcohol ingestion), also includes trying to obtain consent from the patient or responsible family member. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work:

An abdominal incision is made that is large enough to allow evaluation of the entire abdominal cavity. The peritoneal surfaces are inspected for site of violation. Hematomas, crepitus, and bile staining are sought and excluded, including all appropriate maneuvers to inspect the retroperitoneum, such as mobilization of the duodenum, ascending colon, and descending colon, and mobilization of the gastrocolic ligament to inspect the pancreas. The solid viscera are evaluated by inspection and palpation. The gastrointestinal tract from the esophagogastric junction to the peritoneal reflection of the rectum in the pelvis is evaluated and injury excluded. The great vessels of the abdomen and the urinary tract are examined and injury excluded. All other intra-abdominal organs are systematically inspected and the absence of injury is confirmed. The abdomen is closed in layers.

Description of Post-Service Work:

Post-service work begins after skin closure in the operating room and includes the application of sterile dressings. Post-service work also includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including monitoring of cardiopulmonary status; monitoring and care of the incisions; and antibiotic and pain medication management. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure, including removal of sutures; ordering and evaluating periodic laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American College of Surgeons

Sample Size: 175 Response Rate (%): 45 (26%)

	Median	Low	25th pctl	75th pctl	High
RVW:	11.00	8.00	10.00	12.00	13.85
PRE-Service	60				
INTRA-Service	90	60	60	101	150
POST-Service:					
Day of procedure - total time	30				
ICU - total time / # of visits	0	0			
Other hosp. - total time / # of visits	45	3			
Office - total time / # of visits	30	2			

KEY REFERENCE SERVICE(S):

<u>1995 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
11.19	090	49010	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Due to technological advances in diagnostic CAT scans, ultrasonography, MRI, and diagnostic laparoscopy, exploratory laparotomy currently is performed most frequently in trauma patients. As a result, the population of patients requiring this service has changed. In addition, the intensity of the procedure has increased because it is now imperative for the surgeon to exclude all intra-abdominal and retroperitoneal injuries at the time of exploration. The work that is required for this code is equivalent to the work of 49010, which has an RVW of 11.19.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Code 49000 was included in the Harvard project and a work value of 9.05 was recommended. This value is slightly greater than the current work value for this code. Moreover, the work value of 9.05 is based on pre-, intra-, and post-service times that are less than those reported in the five-year review survey.

CPT	Study	Pre-service Time	Intra-service Time	Post-service Hospital Time	Post-service Office Time
49000	Harvard	52	66	42	25
	5-Year Review Survey	60	90	75	30

Public Comments

30-Jun-95

Code: 49000

1995 RVUs: 8.99

Recommended RVUs: 11.60

Ratio:

Long Descriptor: Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)

Reference Set (y/n): Y Global Period: 090 Frequency: 21,415 Impact: 55893

Source: 1 Year: 92 Public Comment Letter: 346

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACS, ASCRS

Societies Wishing to Comment: ACOG, APSA, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
49000	45.8	12.3	11.6	61.5	11.5	1.7	3.3	14.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
49000	24846	23736	-2.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
49000	95	95.7	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
49000	anesthesiology	5.2
	general surgery	71.1
	group practices	2.9
	obstetrics/gynecology	8
	thoracic surgery	3.1
	urology	3
	vascular surgery	2.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
49000			

Public Comments

30-Jun-95

557	1.9	VASCULAR INSUFFICIENCY OF INTESTIN
560	2.4	INTESTINAL OBSTRUCTION WITHOUT M
567	1	PERITONITIS
789	4.9	OTHER SYMPTOMS INVOLVING ABDOM
998	1.2	OTHER COMPLICATIONS OF PROCEDUR

Harvard Data:

Comm	Modif	Packhrv	Pack95	Hrvtotwk	Mfewk95	Ratio5h	Mfewk92
49000							
ACS		090	090	9.05	8.99	0.99	8.99
ASGS		090	090	9.05	8.99	0.99	8.99

Harvard Data:

Comm	Mswk93	Mfewk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
49000								
ACS	8.99	8.99	0.99	1.00	1.00	1.00	11.60	346
ASGS	8.99	8.99	0.99	1.00	1.00	1.00	12.54	185

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
49000								
ACS	090	9.05		31		66		45
ASGS	090	9.05		31		66		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
49000									
ACS		1.0		10	6.5		10	0.0	2.5
ASGS		1.0		10	6.5		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfewk95	Sp	Phase	Twput	lwput
49000									
ACS		10		11.60	8.99	gs	n		0.075
ASGS		10		12.54	8.99	gs	n		0.075

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS

**FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 49180 Global Period: XXX Current RVW: 1.49 Recommended RVW: 2.05

CPT Descriptor: Biopsy, abdominal retroperitoneal mass, percutaneous needle.

Source and Summary of Comment to HCFA on this service: SCVIR. Raise value to median value of other equivalent biopsy services (2.05).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Specialty: _____

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure:

ICU:

Other Hospital:

Office:

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	47000	Biopsy of liver, needle, percutaneous	1.9
2)	32405	Biopsy, lung or mediastinum, percutaneous needle	1.93
3)	50200	Renal biopsy, percutaneous, by trocar or needle	2.63
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

See Rationale

RATIONALE

The current value for this service of 1.49 is inconsistent with other services such as percutaneous liver biopsy (CPT 47000; RVW 1.9), percutaneous lung biopsy (CPT 32405; RVW 1.93), renal biopsy (CPT 50200; RVW 2.63). The median values of these other biopsy codes is 2.05 RVWs. In our opinion, percutaneous biopsy of an abdominal mass clearly requires an equivalent amount of physician time and effort when compared with these other biopsies. For example, biopsy of a 3 cm lesion of the liver requires initial evaluation of previous examinations, laboratory results, and consultation with the family and physician followed by localization of the mass under the imaging guidance of choice. After the skin has been anesthetized and the mass relocalized, a needle is passed through the mass, the position of the needle confirmed, and tissues aspirated or withdrawn. After appropriate specimens are taken, the patient is monitored, orders are written, and the patient and the referring physician are spoken with. The procedure also involves the use of conscious sedation. Biopsy of the kidney, lung, and liver is virtually identical to a biopsy of an abdominal mass; the service is different only in location of the mass and typically does not involve less stress or less difficulty because of the potential hazards from inadvertent puncture of adjacent vital organs or vascular structures. Regarding risks, the risks of bleeding from an abdominal mass are essentially equivalent to the risks of pneumothorax from inadvertent needle passage across the pleural space for example.

Public Comments

30-Jun-95

Code: 49180

1995 RVUs: 1.49

Recommended RVUs: 2.05

Ratio:

Long Descriptor: Biopsy, abdominal or retroperitoneal mass, percutaneous needle

Reference Set (y/n): N Global Period: 000 Frequency: 13,223 Impact: 7405

Source: 2 Year: 92 Public Comment Letter: 317

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ASCRS, SCVIR

Societies Wishing to Comment: ACR, ASIM

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
49180	51.6	9.8	12.2	53.5	6	0.3	1.6	11.2

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
49180	14043	14608	2

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
49180	55.3	53	-1.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
49180	general surgery	4.6
	group practices	4.3
	interventional radiolog	3.7
	radiology	83.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
49180	239	1.1	NEOPLASMS OF UNSPECIFIED NATURE
	786	1.7	SYMPTOMS INVOLVING RESPIRATORY S
	789	9.2	OTHER SYMPTOMS INVOLVING ABDOM

Public Comments

30-Jun-95

V72	9	SPECIAL INVESTIGATIONS AND EXAMIN
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
49180							
SCVIR		000	000	1.73	1.49	0.86	1.49

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
49180								
SCVIR	1.49	1.49	0.86	1.00	1.00	1.00	2.05	317

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
49180								
SCVIR	000	1.73		12	*	22		20

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
49180									
SCVIR	*	0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
49180									
SCVIR	*	0		2.05	1.49	gs	3		0.050

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 49255 **Global Period:** 090 **1995 RVW:** 4.04 **Recommended RVW:** 11.50

CPT Descriptor: Omentectomy, epiploectomy, resection of omentum (separate procedure)

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 14 general surgeons, with the assistance of Abt Associates, Inc., designed a study that included a survey instrument to effectively measure all aspects of physician work for commonly performed general surgery services. The results of this study found code 49255 to be undervalued at the present time.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

45-year-old female patient underwent a pelvic exploration one week ago. The findings of the previous operation were uncertain as to pathology inasmuch as the frozen section diagnosis was unclear. The permanent pathology report indicated a poorly differentiated ovarian carcinoma. The plan is to resect the patient's omentum as completely as possible and to further stage the extent of her disease. The pathologist's report of this specimen showed several small foci of tumor. The patient's postoperative course was satisfactory, and she was discharged on the fifth postoperative day.

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the time of the procedure. This includes obtaining and reviewing previous work-up, with special attention to cardiopulmonary, gastrointestinal, and hematologic status; reviewing findings of the prior operation; reviewing imaging and laboratory studies; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work:

The abdomen is incised, with dissection carried through the abdominal wall and into the peritoneal cavity. The peritoneum is explored for other abnormalities, and adhesions are taken down, as needed. The omentum is mobilized and an omentectomy is performed. The abdominal wall is closed in layers.

Description of Post-Service Work:

Post-service work begins after skin closure in the operating room and includes application of sterile dressings. Post-service work also includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including careful monitoring of cardiopulmonary status; ordering and reviewing postoperative radiographs and laboratory studies; monitoring and care of the incision; and antibiotic and pain medication management. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure including removal of sutures; ordering and evaluating periodic imaging and laboratory reports, if needed; arranging and initiating chemotherapy; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American College of Surgeons

Sample Size: 175 Response Rate (%): 51 (29%)

	Median	Low	25th pctl	75th pctl	High
RVW:	11.50	8.00	10.00	13.00	17.53
PRE-Service	38				
INTRA-Service	90	40	60	115	240
POST-Service:					
Day of procedure - total time	30				
ICU - total time / # of visits	0	0			
Other hosp. - total time / # of visits	70	5			
Office - total time / # of visits	30	3			

KEY REFERENCE SERVICE(S):

1995

<u>RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
9.40	090	49002	Reopening of recent laparotomy
14.10	090	58950	Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy;
6.54	090	58940	Oophorectomy, partial or total, unilateral or bilateral;

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 49002 has an RVW of 9.4. Code 49255 requires the same work as 49002, but it also involves the additional work of an omentectomy and lysis of adhesions. Code 49255 also involves the same amount of work as 58950, but without the oophorectomy. Therefore, in comparison with codes 49002 and 58950, an RVW of 11.50 is recommended for 49255.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Code 49255 was included in the Harvard project, and a work value of 10.25 was recommended. This value is approximately 60 percent greater than the current work value of 4.04 for this code. The Harvard value was based on an intra-service RVW of 5.15, which is greater than the current total work value for this code. Moreover, the value of 10.25 is based on pre-service, intra-service, and post-service hospital times that are slightly less than those reported in the five-year review survey. Code 49255 is listed in the *CPT Manual* as a separate procedure, but it is valued as though it were an add-on.

CPT	Study	Pre-Service Time	Intra-Service Time	Post-Service Hospital Time	Post-Service Office Time
49255	Harvard	31	86	65	30
	5-Year Review Survey	38	90	70	30

Public Comments

30-Jun-95

Code: 49255

1995 RVUs: 4.04

Recommended RVUs: 12.50

Ratio:

Long Descriptor: Omentectomy, epiploectomy, resection of omentum (separate procedure)

Reference Set (y/n): N

Global Period: 090

Frequency: 4,122

Impact: 34872

Source: 2

Year: 92

Public Comment Letter: 346

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACS, ASCRS

Societies Wishing to Comment: ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
49255	37.3	13.3	15.2	84	9.8	4.4	1.8	8.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
49255	4438	4523	1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
49255	93.1	91.2	-0.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
49255	general surgery	58.1
	group practices	2.1
	obstetrics/gynecology	33.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
49255	151	1.3	MALIGNANT NEOPLASM OF STOMACH
	182	3.1	MALIGNANT NEOPLASM OF BODY OF U
	183	3.3	MALIGNANT NEOPLASM OF OVARY AND
	197	1.3	SECONDARY MALIGNANT NEOPLASM O

Public Comments

30-Jun-95

552	4	OTHER HERNIA OF ABDOMINAL CAVITY
553	2.7	OTHER HERNIA OF ABDOMINAL CAVITY
560	1.3	INTESTINAL OBSTRUCTION WITHOUT M
789	3.3	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
49255							
ACS		090	090	10.25	4.04	0.39	4.04

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
49255								
ACS	4.04	4.04	0.39	1.00	1.00	1.00	12.50	346

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
49255								
ACS	090	10.25		31	*	86		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
49255									
ACS	*	1.0		10	6.5	*	10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
49255									
ACS	*	10		12.50	4.04	gs	3		0.060

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 49900 **Global Period:** 090 **1995 RVW:** 4.54 **Recommended RVW:** 9.40

CPT Descriptor: Suture, secondary, of abdominal wall for evisceration or dehiscence

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 14 general surgeons, with the assistance of Abt Associates, Inc., designed a study that included a survey instrument to effectively measure all aspects of physician work for commonly performed general surgery services. The results of this study found code 49900 to be undervalued at the present time.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

71-year-old male underwent a repair of a ruptured abdominal aortic aneurysm six days ago. The patient had known advanced COPD prior to the emergency procedure. His postoperative course was difficult, primarily due to his lung problems. He was maintained on the ventilator for two days and then successfully weaned from it. The patient had severe paroxysms of coughing following extubation. On morning rounds, he was noted to have serosanguineous drainage issuing from his midline wound. Shortly thereafter, an area of the wound opened and small bowel was noted. The patient was returned immediately to the operating room for a secondary closure with wire retention sutures. His postoperative course continued to be a problem due to his persistent bronchitic cough. His wound eventually healed, and his cough subsided. He was discharged three weeks after his initial emergency operation.

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the time of the procedure. This activity includes obtaining and reviewing the previous work-up, with special attention to cardiopulmonary, gastrointestinal, and hematologic status; reviewing imaging and laboratory studies; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervision of the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work:

The abdomen is incised, with removal of all sutures and the dissection is carried through the abdominal wall and into the peritoneal cavity. The peritoneum is explored for other abnormalities, and adhesions are taken down, as needed. The abdomen is lavaged with saline, cultures are taken, and debridement of the abdominal wall, as needed, is done. The abdominal wall is closed in layers, with retention sutures also being placed along with skin.

Description of Post-Service Work:

Post-service work begins after skin closure in the operating room and includes application of sterile dressings. Post-service work also includes monitoring the patient's stability in the recovery room; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including ICU care and ventilator management, as necessary; careful monitoring of cardiopulmonary status; ordering and reviewing postoperative radiographs and laboratory studies; monitoring and care of the incision; and antibiotic and pain medication management. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure, including removal of sutures; ordering and evaluating periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: American College of Surgeons

Sample Size: 175

Response Rate (%): 50 (29%)

	Median	Low	25th pctl	75th pctl	High
RVW:	10.00	7.00	8.78	12.75	18.00
PRE-Service	30				
INTRA-Service	60	40	60	80	120
POST-Service:					
Day of procedure - total time	30				
ICU - total time / # of visits	40	3			
Other hosp. - total time / # of visits	195	15			
Office - total time / # of visits	45	3			

KEY REFERENCE SERVICE(S):

1995

<u>RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
9.40	090	49002	Reopening of recent laparotomy

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The work of 49002 and 49900 is virtually the same. They both require reopening and re-closing a recent incision. They both involve exploration of the peritoneal cavity.

RATIONALE: Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The recommended increase in the RVW for this code (from 4.54 to 9.40) is based on the similarity of the overall work of 49002 and 49900. They both require reopening and reclosing a recent incision. They both involve exploration of the peritoneal cavity.

Code 49900 was reviewed in the Harvard project, and a work value of 6.43 was recommended. This value is 29 percent greater than the current value of 4.54. Moreover, the Harvard value is based on pre-service, intra-service, post-service hospital, and post-service office times that are less than those derived from the five-year review survey. In addition, the Harvard data included no ICU time, as compared to the five-year review survey data, which indicated three ICU visits as part of the work of the surgeon for this procedure.

CPT	Study	Pre-Service Time	Intra-Service Time	Post-Service Hospital Time	Post-Service Office Time
49900	Harvard	26	54	47	25
	5-Year Review Survey	30	60	265	45

Public Comments

30-Jun-95

Code: 49900

1995 RVUs: 4.54

Recommended RVUs: 12.66

Ratio:

Long Descriptor: Suture, secondary, of abdominal wall for evisceration or dehiscence

Reference Set (y/n): N

Global Period: 090

Frequency: 1,939

Impact: 15745

Source: 2

Year: 92

Public Comment Letter: 346

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
49900	44.1	10.2	7.1	28.8	16.9	1.7	1.7	17.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
49900	2568	2120	-9.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
49900	90.3	91.2	0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
49900	colon and rectal surger	2.3
	general surgery	76.3
	group practices	2.8
	obstetrics/gynecology	2.5
	thoracic surgery	3.4
	urology	4
	vascular surgery	2.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
49900			

Public Comments

30-Jun-95

532	1.3	DUODENAL ULCER
540	1.3	ACUTE APPENDICITIS
560	2.1	INTESTINAL OBSTRUCTION WITHOUT M
569	1.3	OTHER DISORDERS OF INTESTINE
682	1.3	OTHER CELLULITIS AND ABSCESS
998	19.9	OTHER COMPLICATIONS OF PROCEDUR

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
49900							
ACS		090	090	6.48	4.54	0.70	4.54

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
49900								
ACS	4.54	4.54	0.70	1.00	1.00	1.00	12.66	346

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
49900								
ACS	090	6.48		26	*	54		37

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
49900									
ACS	*	1.0	*	10	3.0	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
49900									
ACS	*	10		12.66	4.54	gs	3		0.060

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
 FIVE-YEAR REVIEW PROCESS
 SUMMARY OF RECOMMENDATION

CPT Code: 44140 Global Period: 90 Current RVW: 16.97 Recommended RVW: 16.97

CPT Descriptor: Colectomy, Partial; with anastomosis

Source and Summary of Comment to HCFA on this service: ACS- undervalued
 Rec'd RVW = 18.79

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old male with a history of rectal bleeding and anemia undergoes a colonoscopy. He is found to have a single sigmoid carcinoma of 35 cm from the anal verge. This is a 3cm annular lesion. The patient has an outpatient bowel preparation. ON the day of admission, he undergoes a partial colectomy with

Description of Pre-Service Work: Counsel patient for surgery, evaluate preoperative labs, X-rays and EKG. Position patient on operating table. Supervise Foley catheter placement and preparation of operative area.

Description of Intra-Service Work: Proceed with a abdominal exploration and mobilization of colonic segment. Divide colon and isolate and divide mesenteric vessels. Perform intestinal anastomosis and close mesenteric defect.

Description of Post-Service Work: Daily visits to assess wound and intestinal function. Evaluate labs and X-rays. Follow up to assess for anastomotic "leaks".

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgery

Sample Size: 80 Response Rate (%): 40 Median RVW: 18

25th Percentile RVW: 17 75th Percentile RVW: 18.06 Low: 13.75 High: 20

Median Pre-Service Time: 90 Median Intra-Service Time: 150

25th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 180 Low: 90 High: 270

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>120</u>	<u>7</u>
Office:	<u>60</u>	<u>3</u>

gnette continued--at least a 7cm proximal and distal margins incorporating the lesion.
has an uneventful post-operative course and is discharged on the seventh post operative
day.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	44150	Colectomy, total, abdominal, without proctectomy, with ileostomy, or ileoproctostomy	19.04
2)	44130	Excision of Rectal procidentia, with anastomosis; perineal approach	13.03
3)	45153	Colectomy, total, abdominal, without proctectomy, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loopileostomy.	
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Codes 44150 and 44153 involve more pre service counseling and positioning. The operative procedures are more extensive, requiring greater technical skill and physical effort. The post service recovery is more involved in dealing with a stoma or change in bowel function. Code 44130 is less involved with no abdominal incision.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Several colectomy codes were introduced into the five year review process to realign the codes properly within the family of colectomy codes. These codes are best discussed in aggregate so that the entire family is appropriately represented within the RBRBS. The codes involved are 44140, 44141, 44143, 44144, 44145. CPT grouped these codes together because they represent a progression of surgical procedures that generally demonstrate increasing levels of physician work. This increased work involves pre, intra, and post service elements of care. These work elements are not only comprised of increases in time but also in mental effort, judgement, technical skill, and psychological stress. An additional code included in this discussion, 45550, was also offered for review by the CVs for being undervalued it involves a partial colectomy with proctopexy, it is included in this discussion to preserve the proper relationships within the family of codes. The 1995 RVW,s for the primary family of colectomy codes presently range from 16.97 to 21.29. The ASCRS survey instrument provided a slightly higher range, 18 to 22. Code 45550 was grossly undervalued in relation to the colectomy group with a '95 RVw of 13.38

In general, the pre service times were similar throughout the survey. Although the times are similar, the mental effort and judgement are different. Codes 44140 and 44145 are used for elective colon resections. Codes 44141, 44143, and 44144 develop urgent or emergent colon resections and they've increased intensity, mental effort, judgement and psychological stress involving the pre, intra, and post service time.

The intra service times show a progressive increase from code 44140 through code 44145 which properly reflects the increase in difficulty in physically performing each procedure, especially the low rectal dissections within the pelvis detailed in code 44145. The post service times reflect the increased ICU and hospital times for the urgent and emergent procedures, codes 44141, 44143, and 44144, as illustrated in these surveys. The elective cases, 44140 and 44145, do not have the ICU time and increased hospital times frequently seen in the non-elective setting. The surveys demonstrated the highest levels of complexity and intensity throughout the colectomy group with progression from the base code 44140 to code 44145.

Therefore, the ASCRS recommends a realignment in these survey codes maintaining the original range from 16.97 (code 44140) to 21.29 (44145). The ASCRS recommends the intermediate codes (44141, 44143, 44144) increased proportionately according to the ratio established in the survey instrument. In the survey, the median RVw's for codes 44141 and 44143 were 111% of code 44140; thus 44140 =16.97, 44141 =18.83, 44143=18.83. Code 44144 represented 107% of code 44140; 44144=18.15. The recommended values for the intermediate codes align themselves with the CMC proposed value for code 45550 (CMD RVw = 18.68) and a survey RVw (=18). Finally the survey suggested that 44145 was 112% of the base code 44140, thus 44145=20.7. The ASCRS feels that the survey vignette for 44145 did not represent the typical patient requiring a low anterior resection and thus recommended maintaining the current value of 21.29 (which is 125% of the base code 44140).

Public Comments

Code: 44140

1995 RVUs: 16.97

Recommended RVUs: 20.43

Ratio:

Long Descriptor: Colectomy, partial; with anastomosis

Reference Set (y/n): *

Global Period: 090

Frequency: 60,901

Impact: 210717.46

Source: 5

Year: 93

Public Comment Letter: 346

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACS, ASCRS

Societies Wishing to Comment:

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
44140	55.4	15.5	9.8	58.1	3.2	0.3	0.9	14.5

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
44140	69442	67586	-1.3

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
44140	97.4	98.3	0.5

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
44140	colon and rectal surger	5.1
	general surgery	85.4
	group practices	2.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
44140	153	11.2	MALIGNANT NEOPLASM OF COLON
	154	3	MALIGNANT NEOPLASM OF RECTUM, RE
	211	1.8	BENIGN NEOPLASM OF OTHER PARTS O
	560	2.4	INTESTINAL OBSTRUCTION WITHOUT M

Public Comments

30-Jun-95

562	3.6	DIVERTICULA OF INTESTINE
569	1.7	OTHER DISORDERS OF INTESTINE
578	1.1	GASTROINTESTINAL HEMORRHAGE
789	1	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:**Harvard Data:****Harvard Data:****Harvard Data:****Harvard Data:**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 44141 Global Period: 90 Current RVW: 17.36 Recommended RVW 18.83

CPT Descriptor: Colectomy, partial, with skin level cecostomy or colostomy

Source and Summary of Comment to HCFA on this service: ASGS undervalued Rec'd RVW = 18.79

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 72 year old male presents to the emergency department with acute abdominal pain and distention with abdominal x-rays indicative of sigmoid volvulus. Anoscopy and barium enema are unsuccessful in reducing the volvulus. He is taken to the operating room where he undergoes a sigmoid

Description of Pre-Service Work: Emergent/urgent surgery. Counsel patient for surgery. Mark patient for stoma site. Volume resuscitate patient. Evaluate preop labs and x-rays. Position the patient on the operating table. Supervise Foley catheter placement and preparation of operative area.

Description of Intra-Service Work: Proceed with abdominal exploration. Debride all infected or necrotic tissue. Mobilize the colonic segment. Divide the colon and isolate and divide mesenteric vessels. Perform an intestinal anastomosis and establish a proximal diverting colostomy.

Description of Post-Service Work: Daily visits to assess wound and stoma. Evaluate intestinal function. Evaluate labs and x-rays. Follow up to assess for persistent sepsis.

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgery

Sample Size: 80 Response Rate (%): 40 Median RVW: 20

25th Percentile RVW: 18.88 75th Percentile RVW: 20 Low: 14.71 High: 19.65

Median Pre-Service Time: 105 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 150 75th Percentile Intra-Svc Time: 202.5 Low: 90 High: 210

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 45

ICU: 60 2

Other Hospital: 155 8.5

Office: 60 4

mette continued--resection with anastomosis and a proximal colostomy. Postoperatively he does fairly well. After 48 hours in the Intensive Care Unit, he is transferred to the floor. On the 10th postoperative day, he was discharged from the hospital to be followed in the office for colostomy closure.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	44150	Colectomy, total, abdominal, without proctectomy, with eleostomy, or ileoproctostomy	19.04
2)	44130	Excision of rectal procidentia, with anastomosis; perineal approach	13.03
3)	44153	Colectomy, total, abdominal, without proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loopileostomy	
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 44150 involves more colon in the resection but code 44141 is similar because of the various elements associated with urgent/emergent surgery. Code 44153 is more intense involving more counseling and more physical work in preserving sphincter function. Code 44130 is much less involved, with no stoma and no abdominal incision.

RATIONALE

See 44140

Public Comments

30-Jun-95

Code: 44141**1995 RVUs:** 17.36**Recommended RVUs:** 18.79**Ratio:****Long Descriptor:** Colectomy, partial; with skin level cecostomy or colostomy**Reference Set (y/n):****Global Period:** 090**Frequency:** 3,890**Impact:** 5562.7**Source:** 5**Year:** 93**Public Comment Letter:** 346**Reference Services:****CMD Comment:**

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Societies Wishing to Survey: ACS, ASCRS**Societies Wishing to Comment:****Trends Analysis -- Beneficiary Information:**

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
44141	47.1	12.7	8.8	54.9	7.8	0	2.9	17

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
44141	4585	4340	-2.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
44141	97.8	98.2	0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
44141	colon and rectal surger	4
	general surgery	85.1
	group practices	2.2
	thoracic surgery	2.5
	vascular surgery	2.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
44141	153	4.9	MALIGNANT NEOPLASM OF COLON
	154	1.5	MALIGNANT NEOPLASM OF RECTUM, RE

Public Comments

30-Jun-95

197	1.5	SECONDARY MALIGNANT NEOPLASM O
557	2	VASCULAR INSUFFICIENCY OF INTESTIN
560	6.1	INTESTINAL OBSTRUCTION WITHOUT M
562	3.7	DIVERTICULA OF INTESTINE
567	1.7	PERITONITIS
569	6.1	OTHER DISORDERS OF INTESTINE

Harvard Data:**Harvard Data:****Harvard Data:****Harvard Data:****Harvard Data:**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 44143 Global Period: 90 Current RVW: 15 Recommended RVW 18.83

CPT Descriptor: Colectomy, Partial; with end colostomy and closure of the distal segment (Hartmann type procedure)

Source and Summary of Comment to HCFA on this service: ASGS undervalued Rec'd RVW= 7.29

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 55 year old female presents with acute diverticulitis with perforation and free intraperitoneal air. She is taken to the operating room and undergoes a resection of her sigmoid colon for perforated diverticulitis, a stapling of the distal rectal stump and an end sigmoid colostomy. Postoperatively Description of Pre-Service Work: Emergent/urgent surgery. Counsel patient for surgery. Mark patient for stoma site. Volume resuscitate patient. Evaluate preop labs and x-rays. Position the patient on the operating table. Supervise Foley catheter placement and preparation of operative area.
Description of Intra-Service Work: Proceed with abdominal exploration. Debride all infected or necrotic tissue. Mobilize the sigmoid colon and upper mid rectum. Divide proximal colon and divide and close distal rectum. Isolate and divide the mesenteric vessels. Establish a descending colostomy.
Description of Post-Service Work: Daily visits to assess wound and stoma. Evaluate intestinal function. Evaluate labs and x-rays. Follow up to assess for persistent sepsis.

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgery

Sample Size: 80 Response Rate (%): 40 Median RVW: 20.00

25th Percentile RVW: 19.03 75th Percentile RVW: 21 Low: 13.09 High: 33

Median Pre-Service Time: 90 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 150 75th Percentile Intra-Svc Time: 210 Low: 110 High: 300

Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	<u>45</u>	
ICU:	<u>25</u>	<u>2</u>
Other Hospital:	<u>247.5</u>	<u>14</u>
Office:	<u>65</u>	<u>4</u>

Vignette continued--she did well and was discharged on the 14th hospital day.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	44150	Colectomy, total, abdominal, without proctectomy, with ileostomy, or ileoproctostomy	19.04
2)	44130	Excision of rectal procidentia, with anastomosis; perineal approach	13.03
3)	45153	Colectomy, total, abdominal, without proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loopileostomy.	
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 44150 involves more colon in teh resection but code 44141 is similar because of the various elements associated with urgent/emergent surgery. Code 445153 is more intense involving more counseling and more physical work in preserving sphincter function. Code 44130 is much less involved, with no stoma and no abdominal incision.

RATIONALE

See 44140

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Public Comments

30-Jun-95

Code: 44143

1995 RVUs: 15

Recommended RVUs: 18.79

Ratio:

Long Descriptor: Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)

Reference Set (y/n):

Global Period: 090

Frequency: 15,771

Impact: 59772.09

Source: 2

Year: 92

Public Comment Letter: 346

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACS, ASCRS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
44143	56	16.8	7.2	61.4	5.3	0.7	0.5	14.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
44143	17646	17794	0.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
44143	97.9	98.5	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
44143	colon and rectal surger	3.4
	general surgery	86.4
	group practices	2.7
	thoracic surgery	2.1
	vascular surgery	2.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
44143	153	3.2	MALIGNANT NEOPLASM OF COLON
	154	2.7	MALIGNANT NEOPLASM OF RECTUM, RE

Public Comments

30-Jun-95

557	1.2	VASCULAR INSUFFICIENCY OF INTESTIN
560	5.1	INTESTINAL OBSTRUCTION WITHOUT M
562	8.9	DIVERTICULA OF INTESTINE
567	2.2	PERITONITIS
569	5.4	OTHER DISORDERS OF INTESTINE
789	2.3	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:**Harvard Data:****Harvard Data:****Harvard Data:****Harvard Data:**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 44144 Global Period: 90 Current RVW: 15 Recommended RVW 18.15

CPT Descriptor: Colectomy, Partial; with resection, with colostomy or ileostomy and creation of a mucous fistula

Source and Summary of Comment to HCFA on this service: ACS undervalued Rec'd RVW= 18.79

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 65 year old male presents with an intestinal obstruction. He is found to have an unresectable rectosigmoid carcinoma with complete colonic obstruction. He is taken to the operating room and undergoes sigmoid mobilization and transection of the sigmoid with the proximal end brought out as a

Description of Pre-Service Work: Emergent/urgent surgery. Counsel patient for surgery. Mark patient for stoma site. Volume resuscitate patient. Evaluate preop labs and x-rays. Position the patient on the operating table. Supervise Foley catheter placement and preparation of operative area.

Description of Intra-Service Work: Proceed with abdominal exploration. Debride all infected or necrotic tissue. Mobilize the colonic segment. Divide the colon and isolate and divide mesenteric vessels. Perform an intestinal anastomosis and establish a proximal diverting colostomy.

Description of Post-Service Work: Daily visits to assess wound and stoma. Evaluate intestinal function. Evaluate labs and x-rays. Follow up to assess for persistent sepsis.

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgery

Sample Size: 80 Response Rate (%): 40 Median RVW: 20.55

25th Percentile RVW: 18 75th Percentile RVW: 20.55 Low: 11.92 High: 33

Median Pre-Service Time: 90 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 117.5 75th Percentile Intra-Svc Time: 185 Low: 70 High: 270

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 47.5

ICU: 0 0

Other Hospital: 200 10

Office: 60 3

Vignette continued--colostomy and the distal end brought to the midline wound as a mucus fistula. Postoperatively, he does well and he is prepared for chemoradiation therapy. He is discharged from the hospital on the 10th postoperative day.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	44150	Colectomy, total, abdominal, without proctectomy, with ileostomy, or ileoproctostomy	19.04
2)	44130	Excision of rectal procidentia, with anastomosis; perineal approach	13.03
3)	45153	Colectomy, total, abdominal, without proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loopileostomy.	
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 44150 involves more colon in the resection but code 44141 is similar because of the various elements associated with urgent/emergent surgery. Code 445153 is more intense involving more counseling and more physical work in preserving sphincter function. Code 44130 is much less involved, with no stoma and no abdominal incision.

RATIONALE

See 44140

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Public Comments

30-Jun-95

Code: 44144

1995 RVUs: 15

Recommended RVUs: 18.79

Ratio:

Long Descriptor: Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula

Reference Set (y/n):

Global Period: 090

Frequency: 4,080

Impact: 15463.2

Source: 5

Year: 93

Public Comment Letter: 346

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACS, ASCRS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
44144	58.6	18.1	11.2	62.1	6.9	0.9	3.4	12.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
44144	4781	4450	-3.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
44144	97.7	98	0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
44144	colon and rectal surger	2.7
	general surgery	84.7
	group practices	3.6
	vascular surgery	2.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
44144	153	5.6	MALIGNANT NEOPLASM OF COLON
	154	1.7	MALIGNANT NEOPLASM OF RECTUM, RE
	557	3	VASCULAR INSUFFICIENCY OF INTESTIN

Public Comments

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560	5.4	INTESTINAL OBSTRUCTION WITHOUT M
562	3.2	DIVERTICULA OF INTESTINE
567	1.1	PERITONITIS
569	5	OTHER DISORDERS OF INTESTINE
789	2.2	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:**Harvard Data:****Harvard Data:****Harvard Data:****Harvard Data:**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 44145 Global Period: 90 Current RVW: 21.29 Recommended RVW 21.29

CPT Descriptor: Colectomy, Partial; with coloproctostomy (low pelvic anastomosis)

Source and Summary of Comment to HCFA on this service: ACS undervalued Rec'd RVW= 23.62

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 55 year old male is evaluated for rectal bleeding and a decrease in the caliber of his stool. Colonoscopy reveals no other lesions. On rigid sigmoidoscopy, the lower limit of a 3 cm lesion is at 10 cm from the anal verge. Biopsy proves this to be an adenocarcinoma. He is otherwise well. His CEA level is Description of Pre-Service Work: Counsel patient for surgery, evaluate preoperative labs, x-rays and EKG. Position patient on operating table. Supervise Foley catheter placement and preparation of operative area. Description of Intra-Service Work: Proceed with abdominal exploration. Mobilize sigmoid, descending colon and splenic flexure. Take omentum off transverse and descending colon. Mobilize rectum. Divide colon and rectum. Isolate and divide mesenteric vessels. Isolate and protect uterus. Perform anastomosis with Description of Post-Service Work: Daily visits to assess wound and intestinal function. Evaluate labs and x-rays. Follow up to assess for anastomotic "leaks".

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgery

Sample Size: 80 Response Rate (%): 40 Median RVW: 22

25th Percentile RVW: 21.25 75th Percentile RVW: 24 Low: 17 High: 33

Median Pre-Service Time: 120 Median Intra-Service Time: 210

25th Percentile Intra-Svc Time: 180 75th Percentile Intra-Svc Time: 240 Low: 120 High: 270

Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	<u>45</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>180</u>	<u>10</u>
Office:	<u>60</u>	<u>4</u>

CPT Code: 44145

Vignette continued--3.6. He is bowel prepped as an outpatient with antibiotics and GoLytely. On the day of admission, he is taken to the operating room and undergoes a sigmoid colectomy with a low pelvic anastomosis approximately 5 cm from the anal verge. Postoperatively he has an uneventful recovery and is discharged on the 9th postoperative day.

Intra service work continued--pelvis (possibly trans anal instrumentation).

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	44150	Colectomy, total, abdominal, without proctectomy, with eleostomy, or ileoproctostomy	19.04
2)	44130	Excision of rectal procidentia, with anastomosis; perineal approach	13.03
3)	45153	Colectomy, total, abdominal, without proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loopileostomy.	
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

This code compares similarly to code 45153. Code 45153 is more involved with sphincter dysfunction but the rectal dissection and anastomosis are similar. The pre, intra and post service times are all less, but the physical effect and stress are significant.

RATIONALE

See 44140

Public Comments

30-Jun-95

Code: 44145**1995 RVUs:** 21.29**Recommended RVUs:** 23.62**Ratio:****Long Descriptor:** Colectomy, partial; with coloproctostomy (low pelvic anastomosis)**Reference Set (y/n):****Global Period:** 090**Frequency:** 17,203**Impact:** 40082.99**Source:** 5**Year:** 93**Public Comment Letter:** 346**Reference Services:****CMD Comment:**
Societies Wishing to Survey: ACS, ASCRS**Societies Wishing to Comment:****Trends Analysis -- Beneficiary Information:**

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
44145	48.7	10.2	8.6	53.4	3.8	0	0.6	15.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
44145	19336	18961	-1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
44145	97.5	98.3	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
44145	colon and rectal surger	12.9
	general surgery	78.4
	group practices	2.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
44145	153	6	MALIGNANT NEOPLASM OF COLON
	154	8.7	MALIGNANT NEOPLASM OF RECTUM, RE
	211	1.4	BENIGN NEOPLASM OF OTHER PARTS O
	560	1.7	INTESTINAL OBSTRUCTION WITHOUT M

Public Comments

30-Jun-95

562	5.2	DIVERTICULA OF INTESTINE
569	2	OTHER DISORDERS OF INTESTINE

Harvard Data:

Harvard Data:

Harvard Data:

Harvard Data:

Harvard Data:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45303 Global Period: 10 Current RVW: 0.50 Recommended RVW 0.80

CPT Descriptor: Proctosigmoidoscopy, rigid; with dilation any method

Source and Summary of Comment to HCFA on this service: CMD undervalued Rec'd RVW= 0.80

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 68 year old patient who had previously undergone a low anterior resection with a low pelvic anastomosis complains of increasing bouts of constipation, diarrhea, and rectal fullness. Digital examination reveals a stenotic anastomosis that barely admits the index finger. The rigid proctoscopy is

Description of Pre-Service Work: After identifying a stricture or stenosis the patient is counseled. The patient is repositioned in the prone jack-knife or left lateral Sims position.

Description of Intra-Service Work: Rigid proctoscopy identifies the stricture. The area is cleaned of debris and feces. The stricture is dilated with insertion of the proctoscopic obturator. The obturator is removed

Description of Post-Service Work:

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgery

Sample Size: 80 Response Rate (%): 46 Median RVW: 1.75

25th Percentile RVW: 1.3 75th Percentile RVW: 2.3 Low: 1.01 High: 5

Median Pre-Service Time: 15 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 30 Low: 5 High: 60

Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	<u>10</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>0</u>	<u>0</u>
Office:	<u>0</u>	<u>0</u>

Vignette continued--performed and impacted feces are removed from and around the area of the anastomosis. With reinsertion of the rigid proctoscopy, an attempt to dilate the anastomosis is met with resistance. The anastomotic area is then biopsied to open the stenotic anastomosis and allow for passage of the rigid proctoscope and dilation of the anastomosis. The patient is subsequently cautioned about recurrent anastomotic strictures and the possibility of perianal or perirectal bleeding.

Intra service work continued--and hemostasis is achieved.

CMD Comments

30-Jun-95

Code: 45303

1995 RVUs: 0.5

Recommended RVUs: 0.80

Ratio: 0.60

Long Descriptor: Proctosigmoidoscopy, rigid; with dilation, any method

Reference Set (y/n): N

Global Period: 000

Frequency: 2,928

Impact: 878.4

Source: 11

Year: 94

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
45303			
45300	PROCTOSIGMOIDOSCOPY	0.70	000
45305	PROCTOSIGMOIDOSCOPY; BIOPSY	1.01	000

CMD Comment:

This service is out of alignment with 45300 which is used to report a diagnostic proctosigmoidoscopy (RVU = 0.7). It is slightly more time consuming than 45300. This recommendation will correct a rank order problem.

Societies Wishing to Survey: AAP, ACP, ASCRS

Societies Wishing to Comment: AAFP, ACEP, ACS, AOA, ASIM

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
45303	42.4	11.1	6.2	48.5	9.1	0	0	7.3

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
45303	3362	3456	1.4

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
45303	12.3	10.4	-1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
45303		
	colon and rectal surger	15.7
	gastroenterology	14.8
	general surgery	41.3
	general/family practice	7.2
	internal medicine	13.9

Claims-Level Diagnosis Information:

CMD Comments

ICD9	Pct of Time Used	ICD9 Descriptor
45303		
211	2.5	BENIGN NEOPLASM OF OTHER PARTS O
455	6.6	HEMORRHOIDS
560	3.3	INTESTINAL OBSTRUCTION WITHOUT M
562	3	DIVERTICULA OF INTESTINE
564	2	FUNCTIONAL DIGESTIVE DISORDERS, N
565	2.3	ANAL FISSURE AND FISTULA
569	12.9	OTHER DISORDERS OF INTESTINE
787	1.8	SYMPTOMS INVOLVING DIGESTIVE SYS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
45303							
CMD		000	000	1.51	0.50	0.33	0.50

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
45303								
CMD	0.50	0.50	0.33	1.00	1.00	1.00	0.80	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
45303								
CMD	000	1.51		13		22		16

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
45303									
CMD		0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
45303									
CMD	*	0		0.80	0.50	ga	3		0.040

CMD Comments

30-Jun-95

Code: 45550 **1995 RVUs:** 13.38 **Recommended RVUs:** 18.68 **Ratio:** 0.40

Long Descriptor: Proctopexy combined with sigmoid resection, abdominal approach

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 432 **Impact:** 2289.6

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
45550			
	44140 PARTIAL REMOVAL OF COLON	16.97	090

CMD Comment:

This procedure involves about 10% more work than 44140 which is used to report a partial colectomy with anastomosis, valued at 16.97.

Societies Wishing to Survey: ASCRS

Societies Wishing to Comment: ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
45550	66.7	25	0	83.3	8.3	0	0	8.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
45550	609	445	-14.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
45550	95.9	95.1	-0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
45550		
	colon and rectal surger	23.4
	general surgery	65.2
	vascular surgery	3.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
45550			
	103	2.1	PINTA
	154	2.1	MALIGNANT NEOPLASM OF RECTUM, RE

CMD Comments

30-Jun-95

162	2.1	MALIGNANT NEOPLASM OF TRACHEA, B
197	2.1	SECONDARY MALIGNANT NEOPLASM O
230	2.1	CARCINOMA IN SITU OF DIGESTIVE ORG
454	2.1	VARICOSE VEINS OF LOWER EXTREMITI
562	6.3	DIVERTICULA OF INTESTINE
569	14.6	OTHER DISORDERS OF INTESTINE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
45550							
CMD		090	090	13.91	13.38	0.96	13.38

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
45550								
CMD	13.38	13.38	0.96	1.00	1.00	1.00	18.68	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
45550								
CMD	090	13.91		41	*	154		43

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
45550									
CMD	*	1.0	*	10	7.5	*	10	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
45550									
CMD	*	10		18.68	13.38	gs	3		0.049

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
 FIVE-YEAR REVIEW PROCESS
 SUMMARY OF RECOMMENDATION

CPT Code: 46261 Global Period: 90 Current RVW: 6.54 Recommended RVW 7.62

CPT Descriptor: Hemorrhoidectomy, internal and external complex or extensive: fissurectomy

Source and Summary of Comment to HCFA on this service: CMD undervalued Rec'd=7.77

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38 year old female presents with chronic anal fissure and post-um grade 4 bleeding internal hemorrhoids. An extensive internal and external hemorrhoid- my is performed in two quadrants, along with a posterior fissurectomy. Mucosal advancement rought down to cover the fissurectomy site enclosing the complex hemorrhoidal wound. The

Description of Pre-Service Work:
 spital admission and work up, with special attention to diseases that may lead to immune mpromise such as AODM; ordering and reviewing roentenograms and laboratory studies, mminating with the patient, the patient's family, and other health care professionals;

Description of Intra-Service Work:
 itioning the patient, with careful attention fto padding lower extremities prevent peripheral ve damage; insertion of the operating anoscope, injection of anesthetic with or without

Description of Post-Service Work:
 tabilization by communicating with the patient, family, and other health care essionals (including written and telephone reports and orders); careful hospital

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgery

Sample Size: 80 Response Rate (%): 45 Median RVW: 7

25th Percentile RVW: 6 75th Percentile RVW: 9 Low: 5 High: 12.34

Median Pre-Service Time: 60 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 45 High: 150

Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	<u>30</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>0</u>	<u>0</u>
Office:	<u>45</u>	<u>3</u>

Vignette continued--patient is seen in the hospital one day postoperatively and is discharged home. She is followed up in the clinic in one week and seen again on two more occasions postoperatively to assess complete healing of the hemorrhoidal wound and closure of the posterior fissure preventing a posterior keyhole deformity.

Pre Service Work continued--consulting with referring physician, if necessary; and obtaining consent from the patient/or responsible family member.

Intra Service Work continued--epinephrine solution, careful dissection of hemorrhoidal tissue with excision, and suture closure of wound site with close attention to hemostasis, a posterior fissurectomy, mucosal advancement to cover site, all performed with adequate hemostatic control.

Post Service Work continued--monitoring of wound and possibly for pain and management. Additionally, all hospital visits and post discharge office visits for this problem for 90 days after the day of operation are considered part of this post operative work for this procedure; including evaluating laboratory reports and adjusting medication.

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 46280	Surgical Treatment of Anal Fistula (Fistulectomy	5.63
2) 15100	Split graft, trunk, scalp, arms, legs, hands	8.05
3)		
4)		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre service work is greater than for 46280 because of the hospital admission requirement. It is also greater than for 15100. The intra-service work is greater than for 46280, but slightly less than for 15100. The post service work is greater than 46280 and equivalent for greater than 15100.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research

See 46250

CPT Code 46280 continued--Fistulectomy/Fistulotomy); subcutaneous complex or multiple, with or without placement of seton

CPT Code 15100 continued--and/or feet; 100 sqin cm. less, for each percent of body area of infants and children for free skin grafts

CMD Comments

30-Jun-95

Code: 46261

1995 RVUs: 6.54

Recommended RVUs: 7.77

Ratio: 0.19

Long Descriptor: Hemorrhoidectomy, internal and external, complex or extensive; with fissurectomy

Reference Set (y/n): N

Global Period: 090

Frequency: 783

Impact: 963.09

Source: 1

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
46261			
	46260 HEMORRHOIDECTOMY	6.70	090

CMD Comment:

This procedure involves pre and post-service work similar to 46260 which used to report hemorrhoidectomies without fissurectomies (RVU = 6.70) but involves 20 to 30 minutes more intraservice time. This recommendation will correct a rank order problem.

Societies Wishing to Survey:

Societies Wishing to Comment: ACS, ASCRS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
46261	35.7	14.3	7.7	64.3	7.1	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
46261	935	842	-5.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
46261	40	26.1	-6.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
46261		
	colon and rectal surger	36.1
	general surgery	57
	general/family practice	3.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
46261			
	455	30.4	HEMORRHOIDS
	562	1.8	DIVERTICULA OF INTESTINE

CMD Comments

30-Jun-95

565	17.9	ANAL FISSURE AND FISTULA
569	10.7	OTHER DISORDERS OF INTESTINE
751	1.8	OTHER CONGENITAL ANOMALIES OF DI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
46261							
CMD		090	090	7.67	6.54	0.85	6.54

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
46261								
CMD	6.54	6.54	0.85	1.00	1.00	1.00	7.77	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
46261								
CMD	090	7.67		25	*	78		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
46261									
CMD	*	0.5	*	10	2.5	*	10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
46261									
CMD	*	10		7.77	6.54	g	3		0.044

FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 46262 Global Period: 90 Current RVW: 6.77 Recommended RVW: 8.01

CPT Descriptor: Hemorrhoidectomy internal and external, complex or extensive with fistulectomy; with/without fissurectomy

Source and Summary of Comment to HCFA on this service:
JCMD undervalued Rec'd RVW = 7.99

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48 year old male with third degree hemorrhoids had failed medical management in the left lateral and right posterior quadrants. He has also had a previous perianal abscess that has led to a chronic fistula-in-ano, extensive two quadrant hemorrhoidectomies with internal and external hemorrhoidal excisions performed in closure

Description of Pre-Service Work: Hospital admission work up, with special attention to ruling out AODM; ordering and reviewing roentgenograms and laboratory studies; communicating with the patient, the patient's family, and other health care professionals; consulting with referring physicians: if necessary; and obtaining consent from the patient and/or

Description of Intra-Service Work: Positioning the patient, with careful attention to padding the lower extremities prevent peripheral nerve damage; careful insertion of the anoscope, injection of an anesthetic solution with or without epinephrine, careful dissection of the hemorrhoid columns, suturing of the site to obtain adequate hemostasis, careful insertion

Description of Post-Service Work: Patient stabilization recovery room; communicating with the patient, family, and other health care professionals (including written and telephone reports and orders); appropriate evaluation of wound and verbal communication of postoperative orders with family and/or patient including pain management. Additionally, all post-discharge

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgery

Sample Size: 80 Response Rate (%): 45 Median RVW: 7

25th Percentile RVW: 6 75th Percentile RVW: 9 Low: 5 High: 12.34

Median Pre-Service Time: 60 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 45 High: 150

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>0</u>	<u>0</u>
Office:	<u>45</u>	<u>3</u>

Vignette continued--of hemorrhoidal wounds, along with a fistulotomy to excise and resolve the fistula-in-ano. The patient was discharged from the hospital on the day of surgery and is seen postoperatively in a one week period. He is followed on to other subsequent postoperative visits until complete closure of the fistula's wounds and hemorrhoidectomy sites over the 3 month period.

Pre Service Work continued--responsible family members.

Intra Service Work continued--of the anorectal probe to identify fistula tract with appropriate dissection to excise and debride this tissue.

Post Service Work continued--office visits for this problem for 90 days after the day of the operation are considered to be part of the postoperative work for this procedure; including evaluating the wound and adjusting medications.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	46280	Surgical Treatment of Anal Fistula (Fistulectomy/Fistulotomy); subcutaneous	5.63
2)	15100	Split graft, trunk, scalp, arms, legs, hands and/or feet; 100sq in. cm less, for each	8.05
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above. The pre service work for code 46262 is comparable with the work service codes for 46280 and 15100. The intraoperative work component is greater than for 46280 and is compatible with 15100. Post service component is slightly higher than 46280 and is equivalent to 15100.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

See 46250

KEY REFERENCE SERVICES:

- 1) continued --complex or multiple, with or without placement of seton
- 2) continued --percent of body area of infants and children for free skin grafts

CMD Comments

30-Jun-95

Code: 46262 **1995 RVUs:** 6.77 **Recommended RVUs:** 7.99 **Ratio:** 0.18

Long Descriptor: Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 339 **Impact:** 413.58

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
46262			
	46260 HEMORRHOIDECTOMY	6.70	090

CMD Comment:

This procedure involves pre and post-service work similar to 46260 which is used to report hemorrhoidectomies without fissurectomies (RVU - 6.70) but involves 20 to 30 minutes more intraservice time. This recommendation establishes a more accurate relationship in the family codes 46260, 46261, 46262.

Societies Wishing to Survey:

Societies Wishing to Comment: ACS, ASCRS

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
46262	36.4	0	9.1	27.3	18.2	0	0	18.2

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
46262	479	374	-11.6

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
46262	48.4	41.7	-3.4

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
46262		
	colon and rectal surger	39.6
	general surgery	55.1
	general/family practice	2.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
46262			
	455	25	HEMORRHOIDS

CMD Comments

30-Jun-95

565	20.5	ANAL FISSURE AND FISTULA
569	2.3	OTHER DISORDERS OF INTESTINE
686	2.3	OTHER LOCAL INFECTIONS OF SKIN AN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
46262							
CMD		090	090	7.85	6.77	0.86	6.77

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
46262								
CMD	6.77	6.77	0.86	1.00	1.00	1.00	7.99	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
46262								
CMD	090	7.85		25	*	84		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
46262									
CMD	*	0.5	*	10	2.5	*	10	0.0	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
46262									
CMD	*	10		7.99	6.77	gs	3		0.043

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 91122 Global Period: 0 Current RVW: 1.77 Recommended RVW: 1.77

CPT Descriptor: Anorectal manometry

Source and Summary of Comment to HCFA on this service: The value should not be changed. The current survey supports this. The value of 0.66 recommended by the carrier medical directors is only trivially greater than that of a simple anoscopy and grossly undervalues the procedure.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year old woman is becoming reluctant to leave her home because of fecal soiling. She is continent of solid stool but has had slowly worsening incontinence of liquid stool for 3 years. She frequently has rectal urgency. She has had four vaginal deliveries. Recent flexible sigmoidoscopy was normal. You perform and interpret an anorectal manometry study.

Description of Pre-Service Work: Explanation of procedure; review of indications.

Description of Intra-Service Work: Digital rectal exam; insert lubricated multi-channel catheter into rectum 15-20 cm.; perform station pull-through at half-cm. increments, pausing 10-15 secs. between manipulations, to identify the location of the internal anal sphincter and basal pressure. Repeat. Repeat again, with patient squeezing anal sphincter to determine augmented squeeze pressure. Repeat. Pt. then squeezes as hard and as long as possible to determine maximal squeeze pressure and duration. Test sensation with pinprick in 4 quadrants of anus. Measure baseline pressure for 5 mins., then gradually inflate/deflate balloon to/from 5 cc's, 10, 15, 20, 25, 30, 40, 50, 75, 100, 125, and 150 cc's to determine sensing threshold. Look for relaxation response to balloon distention.

Description of Post-Service Work: Analyze tracing, calculate pressures; explain initial impression to patient.

SURVEY DATA:

Specialty: Gastroenterology

Sample Size: 13 Response Rate (%): 27 Median RVW: 1.81

25th Percentile RVW: 1.75 75th Percentile RVW: 2.15 Low: 0.96 High: 3.39

Median Pre-Service Time: 20 mins. Median Intra-Service Time: 30 mins.

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 45 Low: 15 High: 150

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 15

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	46600	Anoscopy, diagnostic	0.50
2)	45330	Sigmoidoscopy, flexible; diagnostic	0.96
3)	91010	Esophageal motility study	1.65
4)	91011	Esophageal motility study with mecholy! or other stimulant	1.98

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Diagnostic anoscopy is straightforward, simple, easy to interpret and takes only a few minutes. Minimal manipulations are required and there is no physiographic record to interpret. Diagnostic sigmoidoscopy typically takes about ten minutes to perform, with no physiographic record. These procedures are simpler and quicker to perform than anorectal manometry. Esophageal motility studies are comparable in duration and complexity to anorectal manometry; time and intensity are also comparable.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The median value of 1.81 derived from the current survey is almost identical to the existing value of 1.77. The rationale of the Medicare Carrier Medical Directors, in recommending a value of only 0.66, was that the value of anoscopy, 0.5, should be added to the value of code 93770 [determination of venous pressure], 0.16. This would suggest that the work of 91122, anorectal manometry, is the same as combining a simple anoscopy with a single pressure measurement, ignoring the many steps involved in anorectal manometry, detailed above. We strongly recommend that the current value of 1.77 be maintained.

CMD Comments

25-Sep-95

Code: 91122

1995 RVUs: 1.77

Recommended RVUs: 0.66

Ratio: -0.63

Long Descriptor: Anorectal manometry

Reference Set (y/n): N

Global Period: 000

Frequency: 2,892

Impact: -3210.12

Source: 2

Year: 92

Public Comment Letter: N

Reference Services:

	Short Descriptor	RVU	Global
91122			
42809	REMOVE PHARYNX FOREIGN BODY	1.76	010
46600	DIAGNOSTIC ANOSCOPY	0.50	000
93770	MEASURE VENOUS PRESSURE	0.16	XXX
99204	OFFICE/OUTPATIENT VISIT, NEW	1.71	XXX
99284	EMERGENCY DEPT VISIT	1.68	XXX

CMD Comment:

The work time and intensity of 91122 is less than 99204 and is similar to the combination of 46600 and 93770.

Societies Wishing to Survey: ASCRS, ASGE

Societies Wishing to Comment: ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
91122	27.1	5.1	10.3	69.5	8.5	0	1.7	3.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
91122	2525	3014	9.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
91122	6.3	5.5	-0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
91122		
	colon and rectal surger	29.7
	gastroenterology	37
	general surgery	11.8
	group practices	6.7

CMD Comments

internal medicine	8
urology	4.5

Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
91122		
455	1.3	HEMORRHOIDS
555	1.7	REGIONAL ENTERITIS
558	1.3	OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS
564	5.5	FUNCTIONAL DIGESTIVE DISORDERS, NOT ELSEWHERE CLASSI- FIED
569	1.7	OTHER DISORDERS OF INTESTINE
787	13.1	SYMPTOMS INVOLVING DIGESTIVE SYSTEM
788	1.3	SYMPTOMS INVOLVING URINARY SYSTEM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfawk95	Ratio5h	Mfawk92
91122							
CMD		000	000	1.12	1.77	1.58	1.77

Harvard Data:

Comm	Mawk93	Mfawk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
91122								
CMD	1.77	1.77	1.58	1.00	1.00	1.00	0.66	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
91122								
CMD	000	1.12	t	.		48	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdadvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
91122									
CMD

Harvard Data:

CMD Comments

25-Sep-95

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfewk95	Sp	Phase	Twput	lwput
91122									
CMD				0.66	1.77	ga	3	0.023	

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Urology

The Carrier Medical Directors commented on and advocated reductions in 39 of the following 43 codes. In most cases the rationale of the CMDs was based on comparison to cross specialty procedures. RVUs were reduced to the level of the RVUs of the cross specialty procedure. The CMDs also attempted to link the reduction of one code in a family to other codes in an effort to maintain the reduction of RVUs throughout the family. Typically the response of the American Urological Association was to survey the code and to refute the cross specialty link established by the CMDs. The rationale established by the AUA was generally compelling in that it was based on anatomical, technical and patient population differences that proved the cross specialty comparisons to be faulty. Usually AUA arguments were supported by survey data that validated their claims when compared to Harvard data. In many instances surveyed intra-work time was greater than Harvard data showed and RVUs turned out to be greater than established 1995 values.

The RUC questioned the AUA arguments against the cross specialty links and subsequent RVU reductions. They evaluated the technical aspects of the arguments and typically came to the conclusion that the reference procedures chosen for comparison by the CMDs were inappropriate. Survey data was also analyzed to determine if time and complexity measures were sufficient to support AUA arguments. The RUC also looked at time and complexity gains to ascertain if increased RVUs were necessary. The basis for many of the CMD comments was comparison between urology codes and codes in other specialties. As part of its review the RUC compared several urology codes to other procedures on the Multispecialty Points of Comparison (MPC) based on the intrawork per unit time (IWPUT). The urology codes proved to be well within expected levels. For example, 50010, *Exploration of Kidney*, has an IWPUT of 0.094, which compares to: 93510, *left heart catheterization*, with an IWPUT of 0.099; 26531, *Revise knuckle with implant*, with an IWPUT of 0.090; 66984, *Remove cataract, insert lens*, with an IWPUT of 0.121; or 61700, *Inner skull vessel surgery*, with an IWPUT of 0.088. Code 54200, *Treatment of penis lesion*, has an IWPUT of 0.038, which compares to: 11642, *Removal of skin lesion*, with an IWPUT of 0.047; 45110, *Removal of rectum*, with an IWPUT of 0.061; or 46260, *Hemorrhoidectomy*, with an IWPUT of 0.049. Generally the RUC found that the CMD recommended reductions were not appropriate, but that rationale and data were also not sufficiently compelling to support specialty recommended increased RVUs. As a result, the RUC recommends that 32 of the 43 codes, be maintained at 1995 levels.

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
50010	Exploration of kidney	10.07	10.07	CMD: Reduce RVU to 8.99; 50010 has less intra-service work than 32100, <i>thoracotomy, major; with exploration and biopsy</i> , 35371, <i>thromboendarterectomy, with or without patch graft; common femoral</i> , and 60220, <i>total thyroid lobectomy, unilateral; with or without isthmusectomy</i> . It has less intensity than 32100, and should not be more than 49000, <i>exploratory laparotomy, exploratory celiotomy with or without biopsy(s)</i> .	This procedure is most similar to 50220, <i>nephrectomy; including partial ureterectomy, any approach including rib resection</i> , which has a work RVU of 15.98. The only difference is that the kidney is not removed in 50010 as it is in 50220. 50010 is clearly different from the procedures cited by the CMDs. 32100 and 49000 do not require the removal of a rib or the mobilization of the kidney or its vascular supply.	2
50020	Drainage of kidney abscess	12.41	12.41	CMD: Reduce RVU to 9.06; The work of CPT code 50020 is slightly greater than code 50010, <i>exploration of kidney</i> ; the relationship is similar to 49020, <i>drain abdominal abscess</i> , and 49000, <i>Exploratory laparotomy, exploratory celiotomy with or without biopsy(s)</i> . It is questionable whether the drainage of an abscess requires more work than an exploration. For example, the <i>drainage of a liver abscess</i> (code 47010, RVU 8.75) is less work than an <i>exploratory laparotomy</i> (code 49000, RVU 8.99).	Drainage of an abscess is not done through exploration but through a percutaneous tube. When an exploratory procedure is required the patients are a more complex and difficult group. Supported by survey data showing median intra-service time of 90 min. and a median RVU of 17.57. The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
50040	Drainage of kidney	13.8	13.80	CMD: Reduce RVU to 10.55; 50040 does not entail the total work intensity or manual labor that 63047, <i>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</i> , does. It does not include the time, intensive, intra-service work or any aspect of 32100, <i>Thoracotomy, major; with exploration and biopsy</i> , nor the intensiveness of 35371, <i>thromboendarterectomy</i> . The increment in work is similar to 49060, <i>Drainage of retroperitoneal abscess</i> , over 49000, <i>Exploratory laparotomy, exploratory celiotomy with or without biopsy(s)</i> .	The open drainage procedure is rarely done, usually drainage is accomplished by a radiologist with a tube. When procedure is required the patients are a more complex and difficult group; supported by survey data showing median intra-service time of 90 min. and a median RVU of 16.50. The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2
50081	Removal of kidney stone	20.58	20.58	CMD: Reduce RVU to 19.98; An increase of 6.5 RVUs for a stone above 2 cm is not consistent with the work. Adding 3.0 RVUs to code 50080, <i>removal of Kidney stone</i> , is more realistic.	Terminology confusion between 50081, <i>nephrostolithotomy</i> , and 50060, <i>nephrolithotomy</i> ; the prior is a percutaneous procedure and the latter is an open procedure; in 50081 size is very important because of procedural difficulties associated with a larger stone. Additionally, the staghorn configuration is typical for stones over 2 cm. The RUC recommends that the RVU remain the same.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
50200	Biopsy of kidney	2.63	2.63	CMD: Reduce RVU to 1.90; Similar in all aspects to 4700, <i>Biopsy of liver, needle; percutaneous</i> .	Anatomical factors make the kidney more difficult to biopsy. Supported by survey data showing median intra-service time of 52.2 min. and a median RVU of 2.88. The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2
50205	Biopsy of kidney	12.69	12.69	CMD: Reduce RVU to 6.75; 50205, <i>open biopsy of kidney</i> , requires no more work, time, or effort than a <i>wedge biopsy of the liver</i> (47100). This procedure is incorrectly valued under the current fee schedule relative to a kidney exploration. Biopsy should be lower than an exploration to be consistent with the relationship of 47010-49000, <i>Exploratory laparotomy, exploratory celiotomy with or without biopsy(s)</i> .	Most renal biopsies are done percutaneously not open; wedge biopsy is done in as an add on to 50205. Supported by survey data showing median intra-service time of 75 min. and a median RVU of 18.50. The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
50220	Removal of kidney	15.98	15.98	CMD: Reduce RVU to 12.97; Value is 50230, <i>Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy</i> , minus one half of 38780, <i>Remove abdomen lymph nodes</i> . The nephrectomy itself is probably less demanding than the radical procedure, simple (50220) not as difficult as radical (50230).	The only difference between a simple procedure and a radical procedure is that the radical is for cancer; this does not necessarily make the simple procedure less difficult; supported by survey data showing median intra-service time of 120 min. and a median RVU of 18.50 (50220) and median intra-service time of 180 min. and a median RVU of 21.00 (50225). The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2
50225	Removal of kidney	18.93	18.93	Same percentage decrease as code 50220 in order to maintain relativity within the nephrectomy family of codes.		
50230	Removal of kidney	20.56	20.56	Society felt that referenced general surgical codes are not realistic benchmarks. The Whipple procedure, 48150, at 40.25 RVUs was used as a benchmark instead and selected services were evaluated based on pre, intra and post-service work value measurements.	Recommended change was less than a 10% increase from the current RVU. The RUC did not believe its survey instrument to be sufficiently precise to detect such small changes, and the specialty provided no compelling evidence to support their comment.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
50234	Removal of kidney & ureter	21.11	21.11	CMD: Reduce RVUs to 17.79 & 19.93; Should be slightly less than a <i>radical nephrectomy</i> (code 50230, RVU 20.56). Percentage decrease from 50234 should be maintained for 50236.	50234 and 50236 are unrelated to 50230. 50236 is a two part procedure the building block of which yields the original RVU. Supported by survey data showing median intra-service time of 180 min. and a median RVU of 23.00 (50234) and median intra-service time of 190 min. and a median RVU of 25.00 (50236). The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2
50236	Removal of kidney & ureter	23.33	23.33			
50240	Partial removal of kidney	20.24	20.24	CMD: Reduce RVU to 17.05; Maintain relationship to 50234 and 50236.	This is an inappropriate comparison. Logic for 50234 and 50236 is flawed as is this. Supported by survey data showing median intra-service time of 180 min. and a median RVU of 25.00. The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
50320	Removal of donor kidney	21.22	21.22	The society believes that this procedure is not properly valued.	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends that the current RVUs be maintained.	2
50390	Drainage of kidney lesion	3.24	1.96	CMD: Reduce RVU to 1.96; The intra-service and post-operative work for 32000, <i>drainage of chest</i> , is comparable to 50390. 31622, <i>Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing</i> , with RVUs of 2.83 is much more complicated than the aspiration of a renal cyst. It requires more skill, judgement, time and is a much greater risk. The procedure is most comparable to 47500, <i>injection for liver x-ray</i> .	The RUC recommends that the RVU be reduced. The CMD comparison is valid.	3
50392	Insert kidney drain	5.59	3.38	CMD: Reduce RVUs to 2.50, 3.50 and 2.50; The work of 44950, <i>Appendectomy</i> , is much greater than 50392 which compares almost identical in work with introduction of a Swan-Ganz catheter (93503) at 2.46. 50393 and 50395 both follow from reduction of 50392.	Comparison of 50392 to 44950 is not valid. The RUC recommends a reduction, but believes that it is more appropriate to maintain ratio between the codes as established by 50390.	3
50393	Insert ureteral tube	6.88	4.16			
50395	Create passage to kidney	5.15	3.38			

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
50590	Fragmenting of kidney stone	9.62	9.62	CMD: Reduce RVU to 6.54; Not a surgical procedure. Intra-service work is comparable to one hour of critical care. Added to this are two hospital visits (99221 and 99231) and 2.5 level 3 office visits. This procedure also needs to be revalued to take into account the change in technology over the past 5-6 years and the apparent increase in technician time vis-a-vis physician time.	In every way this procedure is similar to a surgical procedure; anesthesia is used and urologist is always present. Technology improvements have lessened the need for anesthesia but have lengthened the time. Supported by survey data showing median intra-service time of 80 min. and a median RVU of 11.00. The RUC recommends that the RVU remain the same.	2
50684	Injection for ureter x-ray	0.76	0.76	CMD: Reduce RVU to .50; This is a procedure of such low intensity and effort that it will rarely be done by physicians. It does not compare with effort and skill of <i>indirect laryngoscopy</i> (31505).	A urologist is always present. Procedure is low intensity but takes time. Supported by survey data showing median intra-service time of 20 min. and a median RVU of 0.75. The RUC recommends that the RVU remain the same.	2
50715	Release of ureter	17.6	17.6	CMD: Reduce RVU to 14.00; This code is incorrect valued higher than 50700, <i>ureteroplasty, plastic operation on ureter (eg, stricture)</i> . It is comparable to 50080, <i>removal of stone</i> , at 14.14. It is not as difficult as 50780, <i>ureteroneocystostomy</i> , with a value of 17.31.	50715, an open procedure, is much more difficult than 50700. Reference services chosen by urologists do not compare to those chosen by the CMDs. Supported by survey data showing median intra-service time of 135 min. and a median RVU of 17.50. The RUC recommends that the RVU remain the same.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
51010	Drainage of bladder	2.54	2.54	CMD: Reduce RVU to 1.75; This procedure is not as difficult in technical skills and training as is 31622, <i>bronchoscopy</i> , with 2.83. It is much closer to 47000, <i>biopsy of liver percutaneous</i> , with a value of 1.92.	Patient is not typical. 51010 is an emergency procedure not scheduled as 31622 or 47000 are. Supported by survey data showing median intra-service time of 30 min. and a median RVU of 3.24. The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2
51597	Removal of pelvic structures	35.27	35.27	CMD: Reduce RVU to 32.25; The large difference between this code and <i>pelvic exenteration, female</i> (58240) is due to a difference of over two hours in estimated intra-service time in the Harvard study. There is probably very little real difference in work, so the most practical step would be to average the codes and assign the same RVU to both.	Arbitrary method of averaging similar procedures is not appropriate. On a male or a female the removal of pelvic structures is an extremely demanding and stressful operation. Supported by survey data showing median intra-service time of 300 min. and a median RVU of 35.00. The RUC recommends that the RVU remain the same.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
51600	Injection for bladder x-ray	0.88	0.88	CMD: Reduce RVU to 0.50; It is more comparable to <i>anoscopy</i> (code 46600, RVU 0.5). This procedure is overvalued compared to other diagnostic procedures. The work involved is less than the <i>endometrial biopsy</i> (code 58100, RVU 0.71) and <i>proctosigmoidoscopy</i> (code 45300, RVU 0.7).	Procedure is not performed in the urologist's office and must be scheduled in a radiology, fluoroscopic suite. Supported by survey data showing median intra-service time of 20 min. and a median RVU of 0.90. The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase the RVU.	2
51605	Preparation for bladder x-ray	1.13	0.64	CMD: Reduce RVU to 0.64; Reduction brings this into correct alignment with this family of codes. Proportionate reduction to 51600, <i>Injection for bladder x-ray</i> .	The RUC recommends that the CMD reduction be accepted.	3
51610	Injection for bladder x-ray	1.59	1.05	CMD: Reduce RVU to 0.90; Reduction brings this into correct alignment with this family of codes. Proportionate reduction to 51600, <i>Injection for bladder x-ray</i> .	This procedure is not performed in the urologist's office and must be scheduled in a radiology, fluoroscopic suite. Supported by survey data showing median intra-service time of 20 min. and a median RVU of 1.05. The RUC recommends reducing the RVU to the level of the survey median.	3

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
51700	Irrigation of bladder	0.88	0.88	CMD: Reduce RVU to .50; Reduction brings this into correct alignment with this family of codes. Proportionate reduction to 51600, <i>Injection for bladder x-ray</i> .	Comparison to 51600 is incorrect. 51600 is diagnostic and 51700 is therapeutic. Supported by survey data showing median intra-service time of 20 min. and a median RVU of 1.00. The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2
51720	Treatment of bladder lesion	1.96	1.96	CMD: Reduce RVU to 1.01; This procedure involves the same amount of time but less skill and intensity than <i>thoracentesis</i> . Increment over 51700 should be no more than that of 62289 over 62270 (0.51 RVUs).	The placement of 51720 in the family of chemotherapy codes is appropriate. BDG is a dangerous drug that requires OSHA mandated handling regulations. The RUC recommends that the RVU remain the same.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
51725	Simple cystometrogram	1.51	1.51	CMD: Reduce RVU to 1.10; This procedure is overvalued compared to other diagnostic procedures. The work is no more than a <i>bone marrow aspiration</i> (code 85095, RVU 1.05) or <i>laryngoscopy</i> (code 31575, RVU 1.1).	Procedure is not comparable to 85090 or 31575; global periods are different for compared codes. Supported by survey data showing median intra-service time of 25 min. and a median RVU of 1.80. The society recommended increasing the RVU up to the survey median. However, there was no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2
51726	Complex cystometrogram	1.71	1.71	CMD: Reduce RVUs to 1.25, 0.61, 1.14 and 1.17; Bring these codes into correct alignment with family of codes. Proportionate to reduction of 51725.	Since basis of reduction of 51725 was refuted, these reductions are also recommended for no change in the current RVU. This is supported by survey data showing median intra-service time of 30 (51726) and 20 (51772) min. and a median RVU of 1.71 (51726) and 1.75 (51772). In the case of 51736, the RUC recommends acceptance of the CMD suggested reduction.	2
51736	Urine flow measurement	0.84	0.61			3
51741	Electro-uroflowmetry, first	1.57	1.57			2
51772	Urethra pressure profile	1.61	1.61			

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
51785	Anal/urinary muscle study	1.53	1.53	CMD: Reduce RVU to 0.42; Interpretation only; comparable to <i>EMG of extraocular muscles</i> (code 92265, RVU 0.81).	This Service was through the RUC process in 1994 and received approval. Comparison code has a different global period. This is supported by survey data showing median intra-service time of 20 min. and a median RVU of 1.55. The RUC recommends that the RVU remain the same.	2
51792	Urinary reflex study	1.10	1.10	CMD: Reduce RVU to 0.59; Interpretation only; comparable to 95935, <i>H or F reflex study</i> . The procedure is less extensive than 95925, <i>EMG of extraocular muscles</i> , as 95925 typically involves testing more nerves.	Procedure is not only interpretation. A urologist performs the procedure. 92265 is done by a lab tech and has a different global period. Supported by survey data showing median intra-service time of 20 min. and a median RVU of 1.55. The RUC recommends that the RVU remain the same.	2
51795	Urine voiding pressure study	1.53	1.53	CMD: Reduce RVUs to 1.11 and 1.17; brings these codes into correct alignment with family of codes. Proportionate to reduction of 51725.	The RUC recommends against CMD reduction of 51725 and suggests that the RVU remain the same. This is supported by survey data showing median intra-service time of 25 (51795) and 30 (51797) min. and a median RVU of 2.00 (51795) and 2.00 (51797).	2
51797	Intraabdominal pressure test	1.60	1.60			

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
52007	Cystoscopy and biopsy	3.02	3.02	CMD: Reduce RVUs to 2.37; Brush biopsy involves negligible work beyond ureteral catheterization. 31622, <i>Bronchoscopy</i> , and 52005, <i>GI endoscopy</i> , values do not increase in value if brushings are done.	Comparison to 31622 is not appropriate. 52007 involves general or spinal anesthesia in the operating room. Supported by survey data showing median intra-service time of 45 min. and a median RVU of 4.50. The society recommended increasing the RVU up to the survey median. However, there was no compelling evidence to increase the RVU. The RUC recommends that the RVU remain the same.	2
52270	Cystoscopy & revise urethra	3.84	3.37	CMD: The performance of urethrotomy adds 1.0 RVUs to the base cystourethroscopy code.	The RUC recommends that the CMD reduction be accepted.	3
52275	Cystoscopy & revise urethra	4.70	4.70	CMD: Reduce RVU to 4.01; The present RVU is nearly double the base <i>cystourethroscopy</i> code (52005). Performance in a male may be more difficult but difference should not be as great.	This procedure does not compare to 52005 which is totally visual. Supported by survey data showing median intra-service time of 30 min. and a median RVU of 4.50. The RUC recommends that the RVU remain the same.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
52276	Cystoscopy and treatment	3.93	5.00	CMD: Reduce to 3.43; Proportionate reduction to 52275.	This procedure is more difficult than 52275. It is a more localized more precise version of 52275. Supported by survey data showing median intra-service time of 35 min. and a median RVU of 5.00. Possible rank order anomaly between 52275 and 52276 is shown in the survey data. The RUC recommends that the societies suggested RVU be accepted.	1
52277	Cystoscopy and treatment	6.17	6.17	CMD: Reduce RVU to 3.44; Increment of work over 52000 is the same as for sphincterotomy or ablation over ERCP.	The CMDs chose an inappropriate reference procedure to make this comparison. 52000 is a diagnostic code. Typical patient for 52277 is quadriplegic, spinal anesthesia is required. Supported by survey data showing median intra-service time of 45 min. and a median RVU of 7.50. The society recommended increasing the RVU up to the survey median. However, there is no compelling evidence to increase RVU. The RUC recommends that the RVU remain the same.	2

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*Key (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
52500	Revision of bladder neck	7.82	7.82	CMD: Reduce RVU to 6.82; This is comparable to an <i>appendectomy</i> (44950) with a value of 6.13 or the <i>insertion of an epidural pump buried with catheter</i> (63780) with a value of 6.29. It is less than the value of 29881, <i>knee arthroscopy</i> , with a value of 7.52.	52340 is for pediatric patients who are more complex and difficult. Miss-billing occurs with 52500 because identical language is used in CPT descriptors and 52340 does not specify congenital cases. As a result, 52340 should be referred to CPT for clarification of congenital cases and 52500 should remain unchanged.	2
52510	Dilation prostatic urethra	6.04	6.04	An individual commented that this procedure should be equated to 52601, <i>Transurethral electrosurgical resection of prostate</i> , with 11.51 RVUs.	The RUC recommends that the current value be maintained. There is no compelling evidence to increase the RVU.	2
54200	Treatment of penis lesion	1.01	1.01	Procedure is done under anesthesia. Survey results indicate a median intra-service time of 20 min. and a median RVU of 1.78.	The society recommended increasing the RVU up to the survey median. However, there was no compelling evidence to increase the RVU. The RUC recommends that the current value be maintained.	2
54231	Dynamic cavernosometry	2.04	2.04	The society supported their original recommendation to the RUC of 3.67. Felt that the procedure was worth twice the value of 51726, <i>complex cystometrogram</i> , because it took 15 to 30 min. longer.	The RUC previously made a recommendation of 3.67 RVUs. In addition, the code was before a HCFA refinement panel.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC Rationale	Key *
54640	Suspension of testis	6.55	6.55	The society felt that referenced general surgical codes are not realistic benchmarks. The Whipple procedure, 48150, at 40.25 RVUs was used as a benchmark instead and selected services were evaluated based on pre, intra and post-service work value measurements.	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends that the current RVUs be maintained.	2

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*Key (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3= Adopt specialty/CMD recommended decrease; 4= Adopt increased RVU, but lower than specialty recommended; 5= Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50010

CPT Code: 50010 Global Period: 090 Source: Harvard
Current RVW: 10.07 CMD Recommended RVW: 8.99 AUA Recommended RVW: 10.07
Medicare Frequency: 336 Proposed reduction: 11% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Renal exploration, not necessitating other specific procedures

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment: *50010 has less intra-service work than 32100, 35371, and 60220; less intensity and less post-operative work than 32100; and should not be more than 49000.*

Reference procedures used by CMD

32100 - Thoracotomy, major, with exploration and biopsy (10.07 RVW)

35371 - Thromboendarterectomy, with or without patch graft; common femoral (10.49 RVW)

49000 - Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure) (8.99 RVW)

60220 - Total thyroid lobectomy, unilateral; with or without isthmusectomy (9.86 RVW)

CLINICAL DESCRIPTION OF SERVICE:

Vignette

NO TYPICAL PATIENT

Description of Pre-Service Work:

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation or evaluation at which the decision to provide the procedure was made.

Particular attention is given to patients in the lateral "flank" position to pad the axilla to avoid brachial plexus injury and to assure that the operating room table flex does not put undue pressure on the vena cava, causing hypotension.

Description of Intra-Service Work:

SEE RATIONALE

Description of Post-Service Work:

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of

the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

50010

SURVEY DATA: DID NOT SURVEY

Specialty: _____

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: _____

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	50220	Nephrectomy, including partial ureterectomy, any approach including rib resection	15.98

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Pre, intra and post service work is similar to as CPT 50220 - Nephrectomy

- 1) Time - key reference procedure is similar in time
- 2) Intensity - key reference procedure is similar in intensity

AUA chose not to survey 50010 - renal exploration, because it was not possible to write a typical vignette for this rarely performed procedure. This CPT code is billed when no other code is appropriate; this explains the extremely low Medicare frequency of 336 per year.

The CMDs compared this to 32100 - thoracotomy with biopsy and 49000 - exploratory laparotomy with biopsy.

A "renal exploration" involves removal of a rib, incising three separate muscle layers, mobilizing the entire kidney, mobilizing the vascular supply to the kidney and careful identification of the ureter. These are essentially all of the steps involved in a nephrectomy for benign disease without actually removing the kidney; the only additional action on the part of the surgeon would be to clamp and tie the renal artery and vein to do a nephrectomy.

It should be apparent after this brief description that this is significantly different from an exploratory laparotomy (looking at the abdominal contents). In addition, all of these patients will have a post-operative ileus for three to four days and typically a hospitalization of six to eight days.

Conclusion: "Renal exploration" is realistically "undervalued" at the current RVW of 10.07. The present value should be retained because this procedure is clearly different from the reference procedures cited by the CMDs.

CMD Comments

30-Jun-95

Code: 50010

1995 RVUs: 10.07

Recommended RVUs: 8.99

Ratio: -0.11

Long Descriptor: Renal exploration, not necessitating other specific procedures

Reference Set (y/n): N Global Period: 090 Frequency: 336 Impact: -362.88

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
50010			
	32100 EXPLORATION/BIOPSY OF CHEST	10.07	090
	35371 RECHANNELING OF ARTERY	10.49	090
	49000 EXPLORATION OF ABDOMEN	8.99	090
	60220 PARTIAL REMOVAL OF THYROID	9.86	090

CMD Comment:

50010 has less intraservice work than 32100, 35371, and 60220; less intensity and less post-operative work than 32100; and should not be more than 49000.

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50010	28.6	0	28.6	28.6	0	0	0	28.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50010	416	345	-8.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50010	95.7	97.1	0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50010		
	general surgery	7.8
	urology	88.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
50010			

CMD Comments

30-Jun-95

459	3.6	OTHER DISORDERS OF CIRCULATORY S
590	10.7	INFECTIONS OF KIDNEY
593	10.7	OTHER DISORDERS OF KIDNEY AND UR
998	3.6	OTHER COMPLICATIONS OF PROCEDUR

Harvard Data:

Comm	Modif	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50010						
CMD		090	13.14	10.07	0.77	10.07

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50010								
CMD	10.07	10.07	0.77	1.00	1.00	1.00	8.99	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
50010								
CMD	090	13.14		32	*	93		39

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50010									
CMD	*	1.0	*	10	4.0	*	10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
50010									
CMD	*	15		8.99	10.07	ur	3		0.094

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50020

CPT Code: 50020 Global Period: 090 Source: Harvard
Current RVW: 12.41 CMD Recommended RVW: 9.06 AUA Survey RVW: 17.57
Medicare Frequency: 780 Proposed reduction: 27% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Drainage of perirenal or renal abscess (separate procedure)

Source and Summary of Comment to HCFA on this service: Carrier Medical Director Comment. *The work of CPT code 50020 is slightly greater than code 50010-exploration of kidney; the relationship is similar to 49020 -Drainage of peritoneal abscess and 49000-Exploratory laparotomy. It is questionable whether the drainage of an abscess requires more work than an exploration. For example, the drainage of a liver abscess (code 47010, RVU 8.75) is less work than an exploratory laparotomy (code 49000, RVU 8.99)*

Reference codes used by CMD

49000 - Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure) (RVW 8.99)

49020 - Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess, transabdominal (RVW 9.06)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old woman has poorly-controlled insulin-dependant diabetes, a temperature of 104 degrees, and positive blood cultures. A CT scan of the abdomen and pelvis demonstrates a perirenal abscess extending from the upper pole of the left kidney down to the pelvic brim and dissecting into the ilio psoas muscle.

Description of Pre-Service Work

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation or evaluation at which the decision to provide the procedure was made.

Particular attention is given to patients in the lateral "flank" position to pad the axilla to avoid brachial plexus injury and to assure that the operating room table flex does not put undue pressure on the vena cava, causing hypotension.

Description of Intra-Service Work

A left flank incision is made, the retroperitoneum is opened, 800 cc of pus is drained. The kidney is carefully mobilized and explored, loculations of pus are broken up, the iliopsoas muscle is explored down to the iliac vessels. Multiple drains are placed. The wound is closed in layers.

Description of Post-Service Work

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of

Patient is transferred to the ICU. Drains are slowly advanced, prolonged hospitalization.

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 100% Median RVW: 17.57

25th Percentile RVW: 16.56 75th Percentile RVW: 19.19 Low: 7.0 High: 35.00

Median Pre-Service Time: 70 minutes Median Intra-Service Time: 90 minutes

25th Percentile Intra-Svc Time: 75 minutes 75th Percentile Intra-Svc Time: 120 minutes Low: 45 minutes
High: 210 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>60 minutes</u>	
ICU:	<u>60 minutes</u>	<u>3.5 visits</u>
Other Hospital:	<u>107.5 minutes</u>	<u>8.0 visits</u>
Office:	<u>60 minutes</u>	<u>4.0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	50280	Excision or unroofing of cyst(s) of kidney	14.63
2)	50060	Nephrolithotomy; removal of calculus	18.00

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - similar in time to reference procedure 50060

2) Intensity - key reference procedures are similar in intensity
 Mental effort and judgement Median response 4 of 5
 Technical skill and physical effort Median response 4 of 5
 Psychological stress Median response 4 of 5

The Carrier Medical Directors' (CMD) comment is flawed. This becomes clear from the following statement: "It is questionable whether the drainage of an abscess requires more work than an exploration." Most renal abscesses are drained in the present day by percutaneous tube placement, either by a radiologist or a urologist. The only patients that require open exploration are much more complex patients in whom there is a contraindication or technical reason for not placing a percutaneous tube for drainage.

Therefore, as noted in the vignette and description of intra service work, this is a much more difficult problem and a subset of patients has now been defined that require open drainage. These patients are much more difficult to manage. The AUA survey RVW reflects the increased work involved in this subset of patients -- likewise, the Medicare frequency of 780 procedures further supports that this is an infrequently performed procedure on a very small but difficult subset of patients.

Conclusion: Current RVW of 12.41 is undervalued and the survey results strongly support an increase in work value to 17.57. The CMD-recommended RVW is incorrect due to a misunderstanding of the current management of a perirenal or renal abscess.

CMD Comments

30-Jun-95

Code: 50020

1995 RVUs: 12.41

Recommended RVUs: 9.06

Ratio: -0.27

Long Descriptor: Drainage of perirenal or renal abscess (separate procedure)

Reference Set (y/n): N

Global Period: 090

Frequency: 780

Impact: -2613

Source: 1

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
50020			
49000	EXPLORATION OF ABDOMEN	8.99	090
49020	DRAIN ABDOMINAL ABSCESS	9.06	090

CMD Comment:

The work of CPT code 50020 is slightly greater than code 50010 (exploration of kidney); the relationship is similar to 49020 and 49000. It is questionable whether the drainage of an abscess requires more work than an exploration. For example, the drainage of a liver abscess (code 47010, RVU 8.75) is less work than an exploratory laparotomy (code 49000, RVU 8.99).

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50020	48	4	8	48	0	12	12	8.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50020	862	863	0.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50020	82.6	77.3	-2.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50020		
	general surgery	8.3
	group practices	3.2
	interventional radiolog	4.6
	radiology	65.6
	urology	15.9

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

	ICD9	Pct of Time Used	ICD9 Descriptor
50020			
	038	4	SEPTICEMIA
	344	2	OTHER PARALYTIC SYNDROMES
	590	5	INFECTIONS OF KIDNEY
	591	4	HYDRONEPHROSIS
	593	6	OTHER DISORDERS OF KIDNEY AND UR
	789	7	OTHER SYMPTOMS INVOLVING ABDOM
	V42	2	ORGAN OR TISSUE REPLACED BY TRAN
	V72	6	SPECIAL INVESTIGATIONS AND EXAMIN

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50020								
	CMD		090	090	11.45	12.41	1.08	12.41

Harvard Data:

	Comm	Mewk93	Mfewk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50020									
	CMD	12.41	12.41	1.08	1.00	1.00	1.00	9.06	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
50020									
	CMD	090	11.45		30	*	80		37

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50020										
	CMD	*	1.0	*	10	3.5	*	10	0.0	2.5

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
50020										
	CMD	*	15		9.06	12.41	ur	3		0.091

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50040

CPT Code: 50040 Global Period: 090 Source: Harvard
Current RVW: 13.80 CMD Recommended RVW: 10.55 AUA Survey RVW: 16.50
Medicare Frequency: 400 Proposed reduction: 24% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Nephrostomy, nephrotomy with drainage

Source and Summary of Comment to HCFA on this service: Carrier Medical Director Comment. *Does not entail the total work intensity or manual labor that 63047-laminectomy does. It does not include the time, intensity intra-service work or any aspect that 32100-thoractomy nor the intensity of 35371 - thromboendarterectomy. The increment in work is more similar to 49060 - drainage of abdominal abscess than 49000 - exploratory laparotomy.*

Reference Codes used by CMD:

63047 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis), single vertebral segment; lumbar (RVW 12.76)

32100 - Thoractomy, major; with exploration and biopsy (RVW 10.07)

49000 - Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure) (RVW 8.99)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year old man with a solitary right kidney has an obstructed distal ureter due to pelvic malignancy. Access cannot be gained from below. Because of an enlarged liver, percutaneous access is not possible. For this reason, urologist elects to perform an open nephrostomy.

Description of Pre-Service Work

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation or evaluation at which the decision to provide the procedure was made.

Particular attention is given to patients in the lateral "flank" position to pad the axilla to avoid brachial plexus injury and to assure that the operating room table flex does not put undue pressure on the vena cava, causing hypotension.

Description of Intra-Service Work

A right subcostal flank incision is made, a renal exploration is carried out, the renal pelvis is dissected, the renal artery and vein are identified. A pyelotomy is made, a Randall- stone forceps is passed from a dilated lower pole calyx through the renal parenchymia, a number 18 Foley catheter is then placed through a separate stab wound to the dilated renal pelvis as a nephrostomy tube. A purse string suture is placed around the nephrostomy tube in the renal capsule. The pyelotomy is closed, a drain is placed and the wound is closed in layers.

Description of Post-Service Work

50040

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 99% (78/79) Median RVW: 16.50

25th Percentile RVW: 15.50 75th Percentile RVW: 18.00 Low: 6.15 High: 22.00

Median Pre-Service Time: 60 minutes Median Intra-Service Time: 90 minutes

25th Percentile Intra-Svc Time: 75 minutes 75th Percentile Intra-Svc Time: 105 minutes Low: 40 minutes High: 180 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>75 minutes</u>	<u>5 visits</u>
Office:	<u>60 minutes</u>	<u>4 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	50130	Pyelotomy; with removal of calculus (pyelolithotomy, pelviolithotomy, including coagulum pyelolithotomy)	16.12
2)	50060	Nephrolithotomy; removal of calculus	18.00

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - similar in time to reference procedure 50130

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 4 of 5
Technical skill and physical effort	Median response 4 of 5
Psychological stress	Median response 3 of 5

The Carrier Medical Directors' (CMD) comment compared this procedure to back and chest surgeries. Once again, the CMDs did not understand the recent change in surgical approach to establish a nephrostomy. Most of these procedures are done percutaneously by a radiologist or a urologist. It is very unusual, and indeed rare, for an open nephrostomy to be carried out.

When open nephrostomy is done, as outlined in the vignette, it is done because access cannot be gained by either below (via cystoscopic procedure) or by percutaneous placement of a tube because of an anatomic abnormality. Therefore, this now represents a much more difficult subset of patients. This is again reflected by the Medicare frequency of only 400.

Conclusion: The current RVW of 13.08 is low. The AUA survey RVW of 16.50 more correctly reflects the work for this extremely difficult subset of patients and strongly supports an increase in work value to 16.50.

CMD Comments

30-Jun-95

Code: 50040	1995 RVUs: 13.8	Recommended RVUs: 10.55	Ratio: -0.24
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Long Descriptor: Nephrostomy, nephrotomy with drainage

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 400 **Impact:** -1300

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
50040			
	32100 EXPLORATION/BIOPSY OF CHEST	10.07	090
	49000 EXPLORATION OF ABDOMEN	8.99	090
	63047 REMOVAL OF SPINAL LAMINA	12.76	090

CMD Comment:

50040 does not entail the total work intensity or manual labor that 63047 does. It does not include the time, intensive, intraservice work or any aspect that 32100 nor the intensive of 35371 (thromboendarterectomy). The increment in work is similar to 49060 over 49000.

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50040	45.5	36.4	0	63.6	9.1	0	0	18.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50040	737	414	-25.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50040	71.6	83.6	6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50040		
	general surgery	3.4
	general/family practice	2.4
	radiology	35.3
	urology	57.5

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

ICD9	Pct of Time Used	ICD9 Descriptor
50040		
040	2.3	OTHER BACTERIAL DISEASES
188	2.3	MALIGNANT NEOPLASM OF BLADDER
591	4.5	HYDRONEPHROSIS
592	4.5	CALCULUS OF KIDNEY AND URETER
593	4.5	OTHER DISORDERS OF KIDNEY AND UR
595	4.5	CYSTITIS
596	4.5	OTHER DISORDERS OF BLADDER
V72	4.5	SPECIAL INVESTIGATIONS AND EXAMIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50040							
CMD		090	090	12.74	13.80	1.08	13.80

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50040								
CMD	13.80	13.80	1.08	1.00	1.00	1.00	10.55	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
50040								
CMD	090	12.74		28		96		37

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50040									
CMD		1.0	*	10	4.0		10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
50040									
CMD		15		10.55	13.80	ur	3		0.088

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50081

CPT Code: 50081 Global Period: 090 Source: Harvard
Current RVW: 20.58 CMD Recommended RVW: 16.98 AUA Recommended RVW: 20.58
Medicare Frequency: 805 Proposed reduction: 17% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting or basket extraction; over 2 cm

Source and Summary of Comment to HCFA on this service: Carrier Medical Director Comment. *An increase of 6.5 RVWs because of a stone that is above 2 cm in diameter is not consistent with the work. Adding 3.0 RVWs to code 50080 is more realistic.*

Reference code(s) used by CMD:

50080 - Nephrostolithotomy; under 2 cm (RVW 13.98)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year old man has a staghorn (branched) calculus filling the entire right renal pelvis and most calyces.

Description of Pre-Service Work

Includes services provided from the day before the surgery until the time of the procedure and may include (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery, scheduling intraoperative fluoroscopic x-ray assessment and any other non "skin-to-skin" work in the operating room. Does not include: consultation or evaluation at which the decision to provide the procedure was made.

Particular attention is given to patients in the prone position to position the head and arms properly to avoid neck and brachial plexus injury.

Description of Intra-Service Work

A guide wire is passed through the previously placed percutaneous tube, the tube is removed and a tract is dilated into the lower pole of the kidney and a 34 French Amplatz sheath is placed. Nephroscopy is carried out, the stone is seen directly at the end of the operating sheath. The ultrasonic lithotripter is used to create a cavity and remove stone in the lower calyx. The stone is sequentially fragmented into multiple pieces with the ultrasonic lithotripter and removed with forceps. The bulk of the stone is removed from the renal pelvis, attention is then directed to each calyx where a stone fragment has to be fragmented and removed. During the procedure, nephroscopy is carried out with a flexible instrument on several occasions to visualize and remove other small stone fragments. At the end of the procedure, a reentry nephrostomy tube is placed.

Description of Post-Service Work

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	_____	_____
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ICU:	_____	_____
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Other Hospital:	_____	_____
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Office:	_____	_____
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KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
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RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

This code was originally identified by the Carrier Medical Directors (CMD) because of a misunderstanding in the meaning of the term "nephrostolithotomy". (Original CMD comment from February list is attached. In the original comments of 2/10/95, the CMDs comment pertained to "nephrolithotomy" which is an entirely different surgical procedure altogether. The CMDs queried why it is more difficult to lift out a stone over centimeters than a stone under two centimeters.

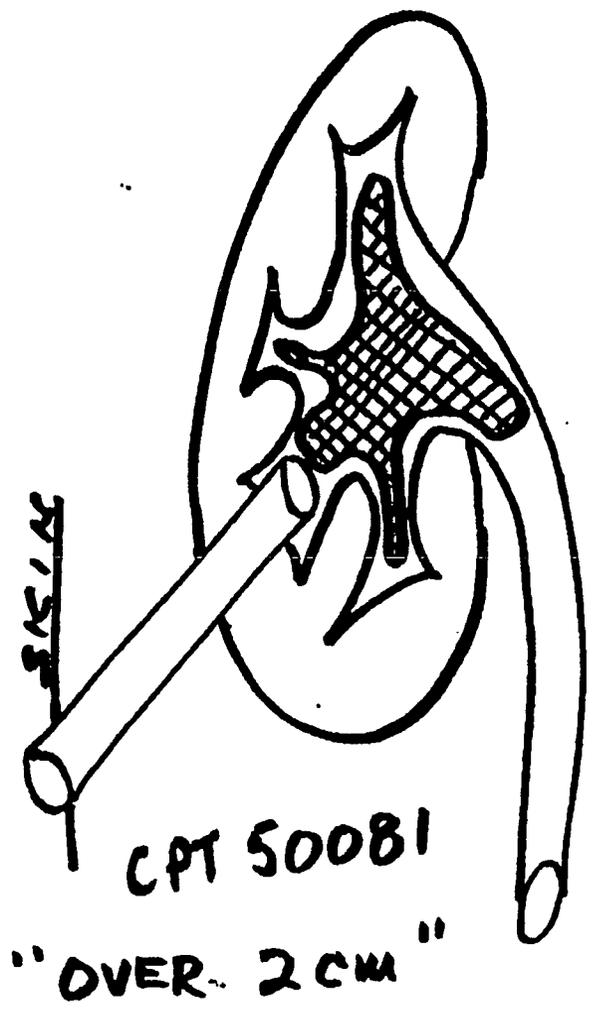
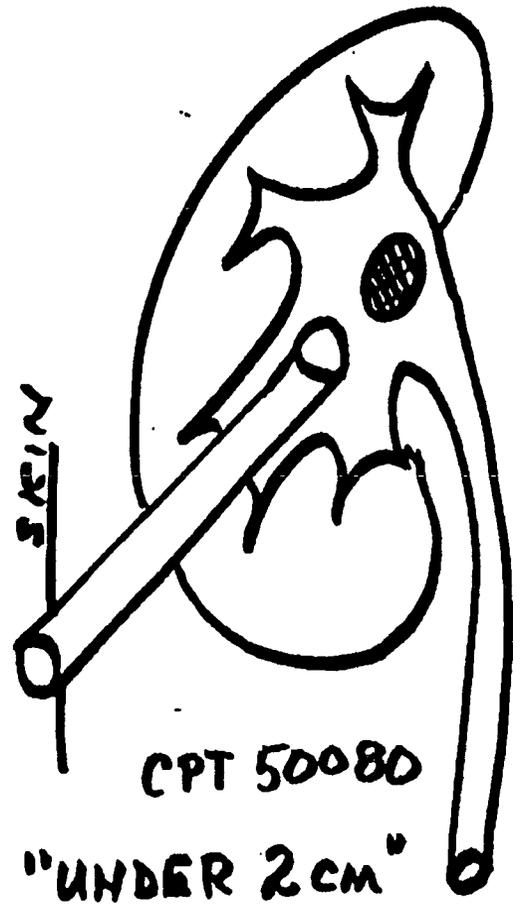
A "nephrolithotomy" CPT 50060 which has not been questioned in the Five-year Review Process is an operation done through a flank incision about ten inches long with a scalpel, scissors and sutures; the kidney is cut open and a stone is removed.

The CMDs did not understand that 50081 is not an open operation. Percutaneous stone surgery has two CPT codes – CPT 50080 (stone under 2 cm) and 50081 (stones over 2 cm). This is because they are very different procedures.

The CPT code identified by the CMDs (50081) "percutaneous nephrostolithotomy" is a percutaneous procedure that has absolutely no resemblance to the nephrolithotomy referenced by the CMDs. This entire code came into question because of the lack of understanding of what is involved in the surgical procedure of a percutaneous nephrostolithotomy.

A "percutaneous nephrostolithotomy" is a procedure done through a percutaneous access whereby a tube about 1 cm in diameter is placed from the skin down into the renal pelvis. Laparoscopic operating instruments are then passed through this tube and a stone is removed. Stones under two centimeters are generally round, free-floating single or multiple stones in the renal pelvis which may be removed by grasping the stone and sometimes fragmenting them if they are too large to fit through the sheath. A nephrostolithotomy of a stone over two centimeters refers to a staghorn calculus which is an entirely different procedure and CPT code (as the enclosed illustration demonstrates) and involves removing stones not only from the renal pelvis, but also the multiple branched components of the stone from multiple calyces. This is a much longer and more difficult surgical procedure and the current RVW of 20.58 may indeed be undervalued for all of the work involved.

Conclusion: The AUA chose not to survey this code because of the misunderstanding by the CMDs in the definition of "nephrostolithotomy" vs "nephrolithotomy." The AUA trusts that the RUC and the CMDs will now understand the complexity of this procedure by this description and will realize that we did not think a survey was indicated. Also, this is an infrequently performed procedure of 805 times in the Medicare population.



DRAFT

CPT CODE 50070 Nephrolithotomy with congenital kidney abnormality

1. 1995 RVUs: 19.15
2. Recommended RVUs: 15.48
3. Reference Code(s): 50060, 50135
4. Rationale for Change:
This is a rational step up in line with the present RVUs. CPT 50135 equates congenital anomalies and reoperation. Companion code to 50060.

CPT CODE 50075 Nephrolithotomy; removal of large staghorn calculus filling renal pelvis and calyces (including anatrophic pyelolithotomy)

1. 1995 RVUs: 24.05
2. Recommended RVUs: 20.00
3. Reference Code(s):
4. Rationale for Change:
This is a rational step up in the same procedure recognizing the complexity and difficulty and intensive of the operation but keeping it in line with the other codes in this series

CPT CODE 50081 Nephrolithotomy; over 2 cm *

1. 1995 RVUs: 20.58
2. Recommended RVUs: 16.98
3. Reference Code(s): 50080 - Slightly increased difficulty from 50080, but not 25 percent more
4. Rationale for Change:
The justification for moving 6½ RVUs because of a stone that is above 2 centimeters in diameter is not justified, therefore, 16.98 was more realistic.

CPT CODE 50120 Pyelotomy; with exploration

1. 1995 RVUs: 15.00
2. Recommended RVUs: 10.00
3. Reference code: 50045 - Recommended 11.18 RVUs
4. Rationale for Change:
The time intensity and difference between the nephrotomy and

CMD Comments

30-Jun-95

Code: 50081

1995 RVUs: 20.58

Recommended RVUs: 16.98

Ratio: -0.17

Long Descriptor: Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting or basket extraction; over 2 cm

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 805 **Impact:** -2898

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
50081			
	50080 REMOVAL OF KIDNEY STONE	13.98	090

CMD Comment:

An increase of 6.5 RVUs because of a stone that is above 2 centimeters in diameter is not consistent with the work. Adding 3.0 RVUs to code 50080 is more realistic.

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50081	31.6	5.3	5.3	42.1	26.3	0	0	5.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50081	720	868	9.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50081	93.2	91	-1.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50081		
	group practices	2.8
	urology	93.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
50081			
	592	23.7	CALCULUS OF KIDNEY AND URETER
	593	1.3	OTHER DISORDERS OF KIDNEY AND UR

CMD Comments

30-Jun-95

596	1.3	OTHER DISORDERS OF BLADDER
598	1.3	URETHRAL STRICTURE
599	1.3	OTHER DISORDERS OF URETHRA AND U
600	1.3	HYPERPLASIA OF PROSTATE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50081							
CMD		090	090	17.63	20.58	1.17	20.58

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50081								
CMD	20.58	20.58	1.17	1.00	1.00	1.00	16.98	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
50081								
CMD	090	17.63		42	*	195		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50081									
CMD	*	1.0	*	10	6.0	*	10	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
50081									
CMD	*	15		16.98	20.58	ur	3		0.060

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 50200 Global Period: 000 Current RVW: 2.66 Recommended RVW: 2.88

CPT Descriptor: Renal biopsy; percutaneous, by Trocar or needle (service includes surgical procedure only)

Source and Summary of Comment to HCFA on this service: Survey of nephrologists randomly chosen from Renal Physician Association membership files, given option of participating and sent tool and support package.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 38 yr. old female who has increased weight by 30 lbs. Known nephrotic/nephritic urine with slowly rising serum creatinine. Resistant to standard diuretic therapy.

Description of Pre-Service Work: Obtaining/reviewing pre-biopsy studies. Discussing studies options and rational of biopsy with patient-family. Obtaining informed consent. Arranging for room availability, arranging for pathology. Reviewing x-ray/ultrasound.

Description of Intra-Service Work: Patient positioned - schooled in appropriate breathing and several "trial" patient maneuvers undertaken. Area is anesthetized with local. Depth of kidney is determined with sound/percutaneous measure. Movement of kidney determined by sound/probe relation to breathing. Renal tissue obtained via needle pass/gun. Tissue evaluated for presence of glomeruli - wound pressure applied.

Description of Post-Service Work: Post biopsy orders given. Post biopsy visit also done communicating with patient and family (referring physician) regarding procedure. Early review of biopsy results. Interpretation of results and decision on therapy possibilities. Follow-up with patient in observation regarding appropriateness for release home. Arrange follow-up visits. Discuss with family signs/symptoms and course of action regarding complications.

SURVEY DATA:

Specialty: Nephrology

Sample Size: 25 Response Rate (%): 12 (48%) Median RVW: 2.88

25th Percentile RVW: 2.0 75th Percentile RVW: 3.63 Low: 1.9 High: 7.0

Median Pre-Service Time: 45 min. Median Intra-Service Time: 52.5 min.

25th Percentile Intra-Svc Time: 44.5 75th Percentile Intra-Svc Time: 61.6 Low: 30 High: 120

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>15</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>15</u>	<u>1.5</u>
Office:	<u>0</u>	

CPT Code: 50200

KEY REFERENCE SERVICE(S):

	<u>CPT Code (%)</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	47000 (50%)	Biopsy of liver, needle; percutaneous	1.92
2)	45100 (40%)	Biopsy of anorectal wall, anal approach	3.42
3)	90937 (40%)	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	2.09
4)			

*% of respondents using this reference service

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

As reflected above, the biopsy of a kidney requires about the same pre-work, but has a much more involved intra-work component. Since the organ is not as superficial as liver, and biopsy is targeted at a small organ, situated quite deeply, surrounded by other vital organs; prone to movement and subject to bleeding, it becomes more difficult to obtain. The actual work is closer to a rectal Bx. The mental and emotional work associated with this procedure is clearly more involved than liver and closer to that of a rectal Bx. The post-work is less than rectal Bx.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The relative value committee of the RPA met in Baltimore to discuss the results of the survey and establish the appropriate value for submission. Discussion centered around the lack of advances over the past 5 years to facilitate the actual percutaneous biopsy. There have been some advances in localization, however, their services are outside the actual biopsy.

Review of respondents showed a significant stress factor (4.2) involved with the biopsy along with moderately high levels of mental judgement (3.8) and technical skills (3.8) noted.

Other discussion centered on cost analysis of reimbursement per procedure and cost increase for malpractice if procedure is included in coverage. The issue, while not directly involved with work, exemplifies a problem. Malpractice would double. The number of procedures to cover this increase in cost of practice is generally not achieved by most practicing nephrologists.

CMD Comments

30-Jun-95

Code: 50200**1995 RVUs:** 2.63**Recommended RVUs:** 1.90**Ratio:** -0.28**Long Descriptor:** Renal biopsy, percutaneous, by trocar or needle**Reference Set (y/n):** N **Global Period:** 000 **Frequency:** 14,774 **Impact:** -10785.02**Source:** 2 **Year:** 92 **Public Comment Letter:****Reference Services:**

	Short Descriptor	RVU	Global
50200			
	47000 NEEDLE BIOPSY OF LIVER	1.90	000

CMD Comment:

Similar in all aspects to 47000.

Societies Wishing to Survey: AAP, RPA, SCVIR**Societies Wishing to Comment:** AUA**Trends Analysis -- Beneficiary Information:**

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50200	17.6	1.4	24.7	44.8	6.2	24.5	22.9	7.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50200	15289	16520	3.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50200	76.7	71.6	-2.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50200		
	general surgery	8.5
	group practices	7.5
	internal medicine	7.4
	nephrology	35
	radiology	34.6
	urology	2.2

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

ICD9	Pct of Time Used	ICD9 Descriptor
50200		
584	1.6	ACUTE RENAL FAILURE
585	2.8	CHRONIC RENAL FAILURE
593	4	OTHER DISORDERS OF KIDNEY AND UR
789	1.6	OTHER SYMPTOMS INVOLVING ABDOM
791	1.2	NONSPECIFIC FINDINGS ON EXAMINATI
996	6.1	COMPLICATIONS PECULIAR TO CERTAI
V42	4.2	ORGAN OR TISSUE REPLACED BY TRAN
V72	4.2	SPECIAL INVESTIGATIONS AND EXAMIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50200							
CMD		000	000	3.77	2.63	0.70	2.63

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50200								
CMD	2.63	2.63	0.70	1.00	1.00	1.00	1.90	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
50200								
CMD	000	3.77		25	*	60		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50200									
CMD	*	0.5		10	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
50200									
CMD		0		1.90	2.63	xx	n		0.042

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50205

CPT Code: 50205 Global Period: 090 Source: Harvard
Current RVW: 12.69 CMD Recommended RVW: 6.75 AUA Survey RVW: 18.50
Medicare Frequency: 877 Proposed reduction: 47% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Renal biopsy, by surgical exposure of kidney

Source and Summary of Comment to HCFA on this service: Carrier Medical Director Comment. *Open biopsy of kidney requires no more work, time, or effort than 47100 - wedge biopsy of the liver. This procedure is incorrectly valued under the current fee schedule relative to a kidney exploration. Biopsy should be lower than an exploration to be consistent with the relationship of 47010-49000.*

Reference Code(s) Used by CMD:

47100 - Biopsy of the liver, wedge (RVW 6.75)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A renal biopsy is indicated in a 67-year old man with a solitary left kidney and hepatosplenomegaly. The nephrologist cannot gain access to the kidney for a percutaneous biopsy. An open renal biopsy is indicated.

Description of Pre-Service Work:

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation or evaluation at which the decision to provide the procedure was made.

Particular attention is given to patients in the lateral "flank" position to pad the axilla to avoid brachial plexus injury and to assure that the operating room table flex does not put undue pressure on the vena cava, causing hypotension.

Description of Intra-Service Work:

A renal exploration is carried out through a left flank incision; the spleen is very large. An incisional wedge biopsy is done. The pathologist examines the tissue. A bolster of fat is placed in the renal biopsy defect and carefully sutured. The wound is closed in layers.

Description of Post-Service Work:

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 97% (77/79) Median RVW: 18.50

25th Percentile RVW: 17.50 75th Percentile RVW: 19.48 Low: 9.00 High: 25.00

Median Pre-Service Time: 60 minutes Median Intra-Service Time: 75 minutes

25th Percentile Intra-Svc Time: 60 minutes 75th Percentile Intra-Svc Time: 90 minutes Low: 30 minutes High: 180 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>60 minutes</u>	<u>4 visits</u>
Office:	<u>30 minutes</u>	<u>2 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	50280	Excision or unroofing of cyst(s) of kidney	14.63
2)	50130	Pyelotomy, with removal of calculus (pyelolithotomy, pelviolithotomy, including coagulum pyelolithotomy)	16.12

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures require less time than 50205.

2) Intensity - key reference procedures are similar in intensity
 Mental effort and judgement Median response 4 of 5
 Technical skill and physical effort Median response 5 of 5
 Psychological stress Median response 5 of 5

The Carrier Medical Directors (CMDs) did not understand the complexity of the procedure and the difficult patient population now involved when an open biopsy of the kidney must be performed. This is incorrectly compared to a wedge biopsy of the liver which is usually done in conjunction with an open exploratory laparotomy. Most renal biopsies are done percutaneously by a nephrologist.

Once again, a subset of patients has been defined in which the nephrologist cannot gain access to the kidney for a percutaneous biopsy. This subset of patients by definition is much more difficult than the standard patient needing a renal biopsy. The vignette used in our survey outlines a patient that might be a candidate for an open biopsy. This is a very difficult patient and this would be a very difficult surgical procedure.

Conclusion: A new subset of patients has been described who would be candidates for an open renal biopsy. This is confirmed by the very low Medicare frequency of 877. The AUA survey result of 18.50 is much closer to the actual work involved rather than the current value of 12.69. The CMD recommended value of 6.75 is grossly incorrect and is based on inaccurate suppositions and the assumption that this procedure is done on "normal" patients. In addition, the survey data is very tight with a 25th percentile of 14.48 and a 75th percentile of 16.50.

CMD Comments

30-Jun-95

Code: 50205

1995 RVUs: 12.69

Recommended RVUs: 6.75

Ratio: -0.47

Long Descriptor: Renal biopsy; by surgical exposure of kidney

Reference Set (y/n): N

Global Period: 090

Frequency: 877

Impact: -5209.38

Source: 1

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
50205			
	47100 WEDGE BIOPSY OF LIVER	6.75	090
	47120 PARTIAL REMOVAL OF LIVER		

CMD Comment:

Open biopsy of kidney requires no more work, time, or effort than a wedge biopsy of the liver (47100). This procedure is incorrectly valued under the current fee schedule relative to a kidney exploration. Biopsy should be lower than an exploration to be consistent with the relationship of 47010-49000.

Societies Wishing to Survey: AAP, AUA

Societies Wishing to Comment: RPA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50205	18.2	0	9.1	27.3	27.3	9.1	9.1	18.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50205	1114	1032	-3.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50205	93.1	94.6	0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50205		
	anesthesiology	18.4
	general surgery	25
	group practices	4.3
	nephrology	5.2
	urology	43.2

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

ICD9	Pct of Time Used	ICD9 Descriptor
50205		
189	2.3	MALIGNANT NEOPLASM OF KIDNEY AN
440	2.3	ATHEROSCLEROSIS
441	2.3	AORTIC ANEURYSM
519	2.3	OTHER DISEASES OF RESPIRATORY SYS
560	2.3	INTESTINAL OBSTRUCTION WITHOUT M
581	2.3	NEPHROTIC SYNDROME
593	13.6	OTHER DISORDERS OF KIDNEY AND UR
V42	2.3	ORGAN OR TISSUE REPLACED BY TRAN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50205							
CMD		090	090	11.58	12.69	1.10	12.69

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50205								
CMD	12.69	12.69	1.10	1.00	1.00	1.00	6.75	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
50205								
CMD	090	11.58		30	*	86		37

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50205									
CMD	*	1.0	*	10	4.5	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
50205									
CMD	*	15		6.75	12.69	ur	3		0.081

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50220

CPT Code: 50220 Global Period: 090 Source: Harvard
Current RVW: 15.98 CMD Recommended RVW: 12.97 AUA Survey RVW: 18.50
Medicare Frequency: 3,174 Proposed reduction: 19% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Nephrectomy, including partial ureterectomy, any approach including rib resection

Source and Summary of Comment to HCFA on this service: Carrier Medical Director Comment. *Value is 50230 minus one half of 38780. The nephrectomy itself is probably less demanding than the radical procedure.*

Reference Codes Used by CMD:

50230 - Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy (RVW 20.56)

38780 - Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure) (RVW 15.17)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year old woman with hypertension, refractory to drug treatment, has been found to have a small scarred left kidney, renal vein renin is elevated and left nephrectomy is indicated to control hypertension.

Description of Pre-Service Work:

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation or evaluation at which the decision to provide the procedure was made.

Particular attention is given to patients in the lateral "flank" position to pad the axilla to avoid brachial plexus injury and to assure that the operating room table flex does not put undue pressure on the vena cava, causing hypotension.

Description of Intra-Service Work:

A left flank incision is made, the 12th rib is resected. Gerota's fascia is opened. The ureter is identified and divided. A renal exploration is carried out. The kidney is mobilized. There is dense scar tissue around the kidney, the renal artery and renal vein are exposed, clamped and tied. The kidney is removed intact. The wound is closed in layers.

Description of Post-Service Work:

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 97% (78/79) Median RVW: 18.50

25th Percentile RVW: 17.50 75th Percentile RVW: 19.48 Low: 9.00 High: 25.00

Median Pre-Service Time: 60 minutes Median Intra-Service Time: 120 minutes

25th Percentile Intra-Svc Time: 90 minutes 75th Percentile Intra-Svc Time: 150 minutes
 Low: 60 minutes High: 210 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>90 minutes</u>	<u>6 visits</u>
Office:	<u>45 minutes</u>	<u>3 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	50230	Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	20.56
2)	50060	Nephrolithotomy; removal of calculus	18.00
3)	50400	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple	18.07

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - similar in time to 50230

2) Intensity - key reference procedures are similar in intensity
 Mental effort and judgement Median response 4 of 5
 Technical skill and physical effort Median response 4 of 5
 Psychological stress Median response 4 of 5

The Carrier Medical Directors (CMDs) mistakenly compared this to a radical nephrectomy (50230) and then subtracted the work of one-half of CPT 38780 retroperitoneal transabdominal lymphadenectomy. **First of all, a radical nephrectomy is performed by retaining the protective envelope of the Gerota's Fascia around the kidney. This is an entirely different surgical approach to the kidney than a "simple nephrectomy" which is performed by opening Gerota's Fascia.** (In the "simple nephrectomy" the adrenal gland is dissected off of the kidney retaining the adrenal with the patient. The word **radical** refers to a patient with cancer of the kidney.) However, CPT 50220 is just as demanding if not more demanding than the radical nephrectomy.

The survey results were extremely tight with the 25th percentile being 17.50 and the 75th percentile 19.48. The surveyees appropriately used key reference services of 50230 (20.56 RVW) and 50060 (18.00) as well as a pyeloplasty (50400) at 18.07.

Conclusion: Current RVW of 15.98 is actually undervalued. The AUA surveyed RVW of 18.00 is more appropriate. The CMD recommended RVW of 12.97 is grossly undervalued. In particular, the CMDs did not have an understanding of what is involved in a nephrectomy as evidenced by the comment. "The nephrectomy itself is probably less demanding than a radical procedure."

CMD Comments

30-Jun-95

Code: 50220

1995 RVUs: 15.98

Recommended RVUs: 12.97

Ratio: -0.19

Long Descriptor: Nephrectomy, including partial ureterectomy, any approach including rib resection;

Reference Set (y/n): N Global Period: 090 Frequency: 3,174 Impact: -9553.74

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
50220			
38780	REMOVE ABDOMEN LYMPH NODES	15.17	090
50230	REMOVAL OF KIDNEY	20.56	090

CMD Comment:

Value is 50230 minus one half of 38780. The nephrectomy itself is probably less demanding than the radical procedure.

Societies Wishing to Survey: AAP, AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50220	33.7	4.3	19.4	58.2	7.6	10.9	14.1	11.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50220	3886	3538	-4.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50220	96.8	97	0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50220		
	general surgery	11
	group practices	2.2
	urology	80.8
	vascular surgery	2.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
50220			

CMD Comments

30-Jun-95

189	6	MALIGNANT NEOPLASM OF KIDNEY AN
441	2.2	AORTIC ANEURYSM
585	2.2	CHRONIC RENAL FAILURE
590	3.5	INFECTIONS OF KIDNEY
591	1.6	HYDRONEPHROSIS
592	2.2	CALCULUS OF KIDNEY AND URETER
593	5.7	OTHER DISORDERS OF KIDNEY AND UR
753	1.9	CONGENITAL ANOMALIES OF URINARY

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50220							
CMD		090	090	16.13	15.98	0.99	15.98

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50220								
CMD	15.98	15.98	0.99	1.00	1.00	1.00	12.97	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
50220								
CMD	090	16.13		36		126		58

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdviadur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50220									
CMD		1.0		10	8.0		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
50220									
CMD		15		12.97	15.98	ur	3		0.082

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50225

CPT Code: 50225 Global Period: 090 Source: Harvard
Current RVW: 18.93 CMD Recommended RVW: 14.14 AUA Survey RVW: 21.00
Medicare Frequency: 360 Proposed reduction: 25% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Nephrectomy, including partial ureterectomy, any approach including rib resection; complicated because of previous surgery on same kidney

Source and Summary of Comment to HCFA on this service: Carrier Medical Director Comment. *Same percentage decrease as code 50220 in order to maintain relativity within the nephrectomy family of codes.*

Reference codes used by CMD:

50220 - Nephrectomy including partial ureterectomy, any approach including rib resection (RVW 15.98)

50130 - with removal of calculus (pyelolithotomy, pelviolithotomy, including coagulum pyelolithotomy) (RVW 16.12)

50135 - Pyelotomy; complicated (e.g. secondary operation, congenital kidney abnormality) (RVW 18.14)

50060 - Nephrolithotomy; removal of calculus (RVW 18.00)

50065 - Nephrolithotomy; secondary surgical operation for calculus (RVW 19.62)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year old man has a poorly functioning, painful, chronically obstructed left kidney, there is a history of two previous left pyelolithotomies. Nephrectomy is indicated.

Description of Pre-Service Work

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation or evaluation at which the decision to provide the procedure was made.

Particular attention is given to patients in the lateral "flank" position to pad the axilla to avoid brachial plexus injury and to assure that the operating room table flex does not put undue pressure on the vena cava, causing hypotension.

Description of Intra-Service Work

Left flank incision, the distal portion of the rib is resected, the Omnitrack retractor system is used, the retroperitoneal space is entered, dense scar tissue surrounds the entire kidney which must be mobilized by sharp dissection, the entire renal pedicle is scarred and the renal artery and vein are located with great difficulty, clamped, tied and divided. Using further sharp and blunt dissection, the kidney is removed. There is significant bleeding. The peritoneum is opened several times during the course of the dissection and must be closed. The wound is closed in layers.

Description of Post-Service Work

50225

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 97% (77/79) Median RVW: 21.00

25th Percentile RVW: 20.00 75th Percentile RVW: 23.00 Low: 18.00 High: 34.00

Median Pre-Service Time: 60 minutes Median Intra-Service Time: 180 minutes

25th Percentile Intra-Svc Time: 145 minutes 75th Percentile Intra-Svc Time: 180 minutes

Low: 15 minutes High: 240 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>90 minutes</u>	<u>7 visits</u>
Office:	<u>45 minutes</u>	<u>3 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	50230	Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	20.56
2)	50400	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting, simple	18.07
3)	50060	Nephrolithotomy; removal of calculus	18.00

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - similar in time to reference procedure 50230

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 4 of 5
Technical skill and physical effort	Median response 5 of 5
Psychological stress	Median response 5 of 5

The Carrier Medical Directors (CMD) rationale to reduce this the same percentage as the previous procedure 50220, is based on the same flawed rationale. This is an extremely demanding procedure and rarely is performed. (Only 360 times in the Medicare population.) The vignette used in the survey demonstrates the problems involved in this type of surgery. These kidneys are typically scarred in, and require a huge amount of work to remove. These are long tedious operations, and once again, they bare no relation to a "radical nephrectomy" as suggested by the CMDs (see also Rationale for 50220).

Conclusion: The current RVW of 18.93 may indeed be low. The AUA survey of 21.00 (with the 25th percentile of 20.00 and the 75th percentile at 23.00) is more accurate. This RVW should be increased to 21.00

CMD Comments

30-Jun-95

Code: 50225

1995 RVUs: 18.93

Recommended RVUs: 14.14

Ratio: -0.25

Long Descriptor: Nephrectomy, including partial ureterectomy, any approach including rib resection; complicated because of previous surgery on same kidney

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 360 **Impact:** -1724.4

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
50225			
	50060 REMOVAL OF KIDNEY STONE	18.00	090
	50065 INCISION OF KIDNEY	19.62	090
	50130 REMOVAL OF KIDNEY STONE	16.12	090
	50135 EXPLORATION OF KIDNEY	18.14	090
	50220 REMOVAL OF KIDNEY	15.98	090

CMD Comment:

Same percentage decrease as code 50220 in order to maintain relativity within the nephrectomy family of codes.

Societies Wishing to Survey: AAP, AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50225	55.6	11.1	0	55.6	11.1	11.1	0	33.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50225	473	407	-7.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50225	97.7	96.6	-0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50225		
	general surgery	2.7
	urology	93.9

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

	ICD9	Pct of Time Used	ICD9 Descriptor
50225			
	189	11.1	MALIGNANT NEOPLASM OF KIDNEY AN
	405	2.8	SECONDARY HYPERTENSION
	585	2.8	CHRONIC RENAL FAILURE
	587	2.8	RENAL SCLEROSIS, UNSPECIFIED
	592	5.6	CALCULUS OF KIDNEY AND URETER
	625	2.8	PAIN AND OTHER SYMPTOMS ASSOCIAT
	789	2.8	OTHER SYMPTOMS INVOLVING ABDOM
	866	2.8	INJURY TO KIDNEY

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50225							
CMD		090	090	17.56	18.93	1.08	18.93

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50225								
CMD	18.93	18.93	1.08	1.00	1.00	1.00	14.14	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
50225								
CMD	090	17.56		38		164		58

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
50225									
CMD		1.0		10	8.5		10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
50225									
CMD		15		14.14	18.93	ur	3		0.067

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50234

CPT Code: 50234 Global Period: 090 Source: Harvard
Current RVW: 21.11 CMD Recommended RVW: 17.79 AUA Survey RVW: 23.00
Medicare Frequency: 1,306 Proposed reduction: 16% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Nephrectomy, with total ureterectomy, and bladder cuff; through same incision

Source and Summary of Comment to HCFA on this service: Carrier Medical Director Comment(s). *Similar percentage decrease from revised 50236.*

Reference codes used by CMD

50220 - Nephrectomy, including partial ureterectomy, any approach including rib resection. (RVW 15.98)

50236 - Nephrectomy with total ureterectomy and bladder cuff; through separate incision (RVW 23.33)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year old man with transitional cell carcinoma of the right renal pelvis

Description of Pre-Service Work

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation or evaluation at which the decision to provide the procedure was made.

Particular attention is given to patients in the lateral "flank" position to pad the axilla to avoid brachial plexus injury and to assure that the operating room table flex does not put undue pressure on the vena cava, causing hypotension.

Description of Intra-Service Work

A right flank incision is made, the distal portion of the 11th rib is resected, the incision is carried obliquely onto the right lower quadrant. The entire kidney, including lymph node bearing tissue along the vena cava is mobilized and a nephrectomy is carried out. The ureter is mobilized down below the pelvic vessels to the bladder. A circumferential incision is made around the bladder to include the intramural ureter. The defect in the bladder is repaired after the entire specimen (kidney and ureter) is removed. The wound is irrigated and closed in layers.

Description of Post-Service Work

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

SURVEY DATA:

50234

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 99% (77/79) Median RVW: 23.00

25th Percentile RVW: 21.00 75th Percentile RVW: 24.00 Low: 18.00 High: 30.00

Median Pre-Service Time: 60 minutes Median Intra-Service Time: 180 minutes

25th Percentile Intra-Svc Time: 150 minutes 75th Percentile Intra-Svc Time: 205 minutes

Low: 50 minutes High: 300 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>105 minutes</u>	<u>7 visits</u>
Office:	<u>50 minutes</u>	<u>3 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	50230	Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	20.56

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - reference procedure 50230 is similar in time

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement Median response 4 of 5

Technical skill and physical effort Median response 4 of 5

Psychological stress Median response 4 of 5

RATIONALE

50234

The Carrier Medical Directors (CMD) argue that there should be a "similar percentage decrease from revised 50236." From the discussion of 50236 it should be clear that this is an extremely different procedure than a radical nephrectomy.

In this procedure, a flank incision is made which is extended down into the lower abdomen in curvilinear fashion. A nephrectomy is carried out and the entire ureter is mobilized to the bladder. **The ureter is taken off the base of the bladder, and the bladder defect must also be repaired.** This is two operations.

Conclusion: Retain current RVW of 21.11 or increase RVW to 23.00.

CMD Comments

30-Jun-95

Code: 50234

1995 RVUs: 21.11

Recommended RVUs: 17.79

Ratio: -0.16

Long Descriptor: Nephrectomy with total ureterectomy and bladder cuff, through same incision

Reference Set (y/n): N Global Period: 090 Frequency: 1,306 Impact: -4335.92

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
50234			
	50220 REMOVAL OF KIDNEY	15.98	090
	50236 REMOVAL OF KIDNEY & URETER	23.33	090

CMD Comment:

Similar percentage decrease from revised 50236 (see below).

Societies Wishing to Survey: AAP, AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50234	61.9	21.4	7.1	54.8	2.4	0	0	7.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50234	1519	1425	-3.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50234	96.7	96.8	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50234		
	general surgery	2.3
	urology	95.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
50234			
	188	2.4	MALIGNANT NEOPLASM OF BLADDER
	189	16.7	MALIGNANT NEOPLASM OF KIDNEY AN

CMD Comments

30-Jun-95

236	1.2	NEOPLASM OF UNCERTAIN BEHAVIOR O
593	3.6	OTHER DISORDERS OF KIDNEY AND UR
599	3.6	OTHER DISORDERS OF URETHRA AND U

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50234							
CMD		090	090	19.48	21.11	1.08	21.11

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50234								
CMD	21.11	21.11	1.08	1.00	1.00	1.00	17.79	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
50234								
CMD	090	19.48		39		180		59

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50234									
CMD		1.5		10	8.5		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
50234									
CMD		15		17.79	21.11	ur	3		0.072

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50236

CPT Code: 50236 Global Period: 090 Source: Harvard
Current RVW: 23.33 CMD Recommended RVW: 19.93 AUA Survey RVW: 25.00
Medicare Frequency: 879 Proposed reduction: 15% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Nephrectomy with total ureterectomy and bladder cuff; through separate incision

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *Should be slightly less than a radical nephrectomy whose RVW = 20.56.*

Reference code(s) used by the CMD

50220 - Nephrectomy, including partial ureterectomy, any approach including rib resection. (RVW 15.98)

50230 - Nephrectomy, including partial ureterectomy; any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy. (RVW 20.56)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old man with transitional cell carcinoma of the right renal pelvis and mid-right ureter.

Description of Pre-Service Work

Includes services provided from the day before the surgery until the time of the procedure and **may** include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. **Does not include:** Consultation or evaluation at which the decision to provide the procedure was made.

Particular attention is given to patients in the lateral "flank" position to pad the axilla to avoid brachial plexus injury and to assure that the operating room table flex does not put undue pressure on the vena cava, causing hypotension.

Description of Intra-Service Work

A right flank incision is made, the distal portion of the 11th rib is resected, the kidney is mobilized using sharp and blunt dissection, lymph node bearing tissue along the vena cava is dissected, a nephrectomy is carried out. The ureter is mobilized down to the back of the bladder through this incision; the kidney and mobilized ureter are placed in the pelvis next to the bladder. The wound is irrigated and closed in layers.

The patient is then taken out of the flank position and placed supine on the operating table, the lower abdomen is re-prepped the patient is entirely re-draped. A midline lower abdominal incision is made, the bladder is exposed and opened. The right ureteral orifice is incised and dissected free from the bladder removing the entire remaining portion of the ureter along with a cuff of bladder including the ureteral orifice. The bladder defect is then closed in layers. The cystotomy for exposure of the bladder is closed in layers. A Jackson-Pratt drain is placed and the lower abdominal incision is closed.

Description of Post-Service Work

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization,

post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

SURVEY DATA:Specialty: AMERICAN UROLOGICAL ASSOCIATIONSample Size: 79 Response Rate (%): 97% (77/79) Median RVW: 25.0025th Percentile RVW: 22.83 75th Percentile RVW: 26.11 Low: 18.00 High: 35.00Median Pre-Service Time: 60 minutes Median Intra-Service Time: 190 minutes25th Percentile Intra-Svc Time: 180 minutes 75th Percentile Intra-Svc Time: 240 minutesLow: 120 minutes High: 315 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>50 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>115 minutes</u>	<u>8 visits</u>
Office:	<u>60 minutes</u>	<u>4 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	50230	Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	20.56
2)	55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	26.73

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedure 50230 requires less time.

2) Intensity - key reference procedures are similar in intensity
 Mental effort and judgement Median response 4 of 5
 Technical skill and physical effort Median response 4 of 5
 Psychological stress Median response 4 of 5

The Carrier Medical Directors' (CMD) comment that "50236 should be slightly less than a radical nephrectomy whose RVW is 20.56" demonstrates more clearly than any other CPT code singled out their lack of understanding of urologic surgery. This operation is unrelated to a radical nephrectomy. The description of intra service work from the survey describes a patient in which first a flank incision is made. A nephrectomy is done and then with the kidney still attached to the ureter the kidney is placed down on the pelvis and the entire flank incision is closed.

Next, all of the drapes are removed from the patient and the patient is taken out of the flank position and repositioned supine on the operating table while still under anesthesia. This requires a great deal of coordination with the anesthesiologist and the circulating personnel as well as the physicians. The lower abdomen is then prepped and the patient is entirely redraped and the physicians must scrub and regown again.

Finally, a lower abdominal midline incision is made and the bladder is opened and essentially a ureterectomy CPT 50650 with RVW of 16.37 is carried out. After the ureter is dissected free from the bladder along with a cuff of bladder, the entire kidney, ureter and portion of bladder are removed as one specimen. The posterior defect in the bladder must then be closed. A suprapubic tube must be placed, then the bladder must be closed, followed by the lower abdominal incision. This procedure is a huge amount of work and the AUA is hopeful that the CMDs will understand the difference by the above explanation. In addition, the survey data with a 25th percentile of 20.83 and a 75th percentile of 26.11 are very tight, the AUA survey recommendation of 25.00 is closer to the mark.

Conclusion: Retain current RVW of 23.33, or appropriately increase RVW to 25.00

CMD Comments

30-Jun-95

Code: 50236 1995 RVUs: 23.33 Recommended RVUs: 19.93 Ratio: -0.15

Long Descriptor: Nephrectomy with total ureterectomy and bladder cuff, through separate incision

Reference Set (y/n): N Global Period: 090 Frequency: 879 Impact: -2988.6

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
50236			
50220	REMOVAL OF KIDNEY	15.98	090
50230	REMOVAL OF KIDNEY	20.56	090

CMD Comment:

Should be slightly less than a radical nephrectomy (code 50230, RVU = 20.56).

Societies Wishing to Survey: AAP, AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50236	33.3	11.1	3.8	25.9	3.7	0	0	16

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50236	914	950	2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50236	95.8	97.9	1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50236		
	urology	96.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
50236			
	188	1.9	MALIGNANT NEOPLASM OF BLADDER
	189	17.6	MALIGNANT NEOPLASM OF KIDNEY AN
	236	1.9	NEOPLASM OF UNCERTAIN BEHAVIOR O

CMD Comments

30-Jun-95

591	2.8	HYDRONEPHROSIS
599	4.6	OTHER DISORDERS OF URETHRA AND U

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50236							
CMD		090	090	21.46	23.33	1.09	23.33

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50236								
CMD	23.33	23.33	1.09	1.00	1.00	1.00	19.93	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
50236								
CMD	090	21.46		39		214		59

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50236									
CMD		1.5		10	8.5		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
50236									
CMD		15		19.93	23.33	ur	3		0.070

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50240

CPT Code: 50240 Global Period: 090 Source: Harvard
Current RVW: 20.24 CMD Recommended RVW: 17.05 AUA Survey RVW: 25.00
Medicare Frequency: 788 Proposed reduction: 16% Harvard (Dum) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Nephrectomy, partial

Source and Summary of Comment to HCFA on this service: Carrier Medical Director Comment. *Maintaining relationship to 50234 and 50236.*

Reference code used by CMD:

47120 - Hepatectomy, resection of liver; partial lobectomy (RVW 19.99)

50234 - Nephrectomy with total ureterctomy and bladder cuff; through same incision (RVW 21.11)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year old woman with a solitary right kidney has a 4 cm renal cell carcinoma occupying the mid and lower portion of the kidney. Treatment alternatives are discussed in detail with the patient and family. Partial nephrectomy is decided upon.

Description of Pre-Service Work

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) Communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation and evaluation at which the decision to provide the procedure was made.

Description of Intra-Service Work

An upper abdominal chevron incision is made, the Omnitrack System is used, the right colon is taken down, the duodenum is mobilized and retracted medially, exposing the vena cava and renal vessels. The entire kidney is mobilized and a Rommel type clamp is placed around the renal artery and renal vein. Tapes are placed around the individual renal vessels. A rubber dam is placed around the kidney and it is slushed down with ice, the renal artery is temporarily occluded and the mass is excised. Openings in the pelvis (urinary system) are closed. Intermittently releasing the clamp on the renal artery, multiple bleeders are identified and suture ligated. A large portion of fat is placed in the renal defect and sutured in place. The rubber dam is removed and the renal artery is unclamped, hemostasis is adequate. Drains are left and the incision is closed.

Description of Post-Service Work

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

The Carrier Medical Directors' (CMD) comment was "maintain relationship to 50234 and 50236." A partial nephrectomy is a totally different, completely unrelated procedure to a radical nephrectomy which is inappropriately used as a comparison for 50234 and 50236.

The description of intra service work well-outlines what is involved. A partial nephrectomy is more difficult in many ways than a radical nephrectomy. It is a tissue-sparing operation with a Medicare frequency of only 788.

The procedure involves typically a solitary kidney with cancer. The alternative is a nephrectomy in which case the patient will have to be on dialysis. The renal vascular system must be completely dissected. The renal artery, must be clamped while a portion of the kidney is removed, the kidney must then be repaired and made water tight, the multiple bleeding defects must be stopped. The renal artery must be opened periodically to flush the kidney out to retain viability. These patients go to the ICU afterwards.

The AUA survey results suggest that an appropriate RVW is 25.00. Please notice that this procedure was rated more difficult than a radical nephrectomy.

Conclusion: The CMD rationale is flawed. The CMD rationale is essentially an incorrect premise based on two previous incorrect premises. The current value of 20.24 should be maintained or increased to the survey RVW of 25.00.

CMD Comments

30-Jun-95

Code: 50240

1995 RVUs: 20.24

Recommended RVUs: 17.05

Ratio: -0.16

Long Descriptor: Nephrectomy, partial

Reference Set (y/n): N

Global Period: 090

Frequency: 788

Impact: -2513.72

Source: 1

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
50240			
	47120 PARTIAL REMOVAL OF LIVER	19.99	090
	50234 REMOVAL OF KIDNEY & URETER	21.11	090

CMD Comment:

Maintaining relationship to 50234 and 50236.

Societies Wishing to Survey: AAP, AUA

Societies Wishing to Comment:

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50240	27.3	9.1	9.1	40.9	13.6	0	0	0

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
50240	851	865	0.8

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50240	97.2	96.8	-0.2

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
50240		
	general surgery	8.7
	group practices	4.4
	urology	83.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
50240			
	153	1.1	MALIGNANT NEOPLASM OF COLON

CMD Comments

30-Jun-95

154	1.1	MALIGNANT NEOPLASM OF RECTUM, RE
189	9.1	MALIGNANT NEOPLASM OF KIDNEY AN
198	2.3	SECONDARY MALIGNANT NEOPLASM O
239	1.1	NEOPLASMS OF UNSPECIFIED NATURE
440	2.3	ATHEROSCLEROSIS
593	8	OTHER DISORDERS OF KIDNEY AND UR
599	2.3	OTHER DISORDERS OF URETHRA AND U

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50240							
CMD		090	090	18.72	20.24	1.08	20.24

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50240								
CMD	20.24	20.24	1.08	1.00	1.00	1.00	17.05	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
50240								
CMD	090	18.72		37		158		59

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50240									
CMD		1.5		10	8.5		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
50240									
CMD		15		17.05	20.24	ur	3		0.077

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

50590

CPT Code: 50590 Global Period: 090 Source: Harvard
 Current RVW: 9.62 CMD Recommended RVW: 6.54 AUA Recommended RVW: 11.00
 Medicare Frequency: 28,932 Proposed reduction: 32% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Lithotripsy, extracorporeal shockwave

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *Not a surgical procedure. Intra-service work is comparable to one hour of critical care. Added to this are two hospital visits (99221 and 99231) and 2.5 level three office visits. This procedure also needs to be revalued to take into account the change in technology over the past 5 - 6 years and the apparent increase in technician time vis-a-vis physician time.*

CLINICAL DESCRIPTION OF SERVICE:

Vignette: A 66-year old man has a 1.2 cm round calcium oxalate dihydrate stone in the left renal pelvis. The stone was previously obstructing and a ureteral stent was placed one week prior to the date of lithotripsy.

Description of Pre-Service Work:

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) Communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation and evaluation at which the decision to provide the procedure was made.

Description of Intra-Service Work:

Stone position is checked for placement at the F2 focus. Adjustment of anesthesia parameters (heart rate modification with atropine, tidal volume etc) as directed by the urologist to increase the treatment efficacy. Initial treatment energy is determined by the urologist based upon therapeutic individualization for this patient and estimated stone fragility. Treatment commences and periodic and/or continuous monitoring by x-ray/fluoroscopy is performed with interpretation by the urologist who is in continuous attendance throughout the procedure. After 3,000 shockwaves adequate fragmentation occurs.

Description of Post-Service Work:

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

SURVEY DATA:

Specialty:

Sample Size: 110 Response Rate (%): 41% Median RVW: 11.00

25th Percentile RVW: 9.06 75th Percentile RVW: 13.00 Low: 3.01 High: 20.00

Median Pre-Service Time: 45 minutes Median Intra-Service Time: 80 minutes

25th Percentile Intra-Svc Time: 60 minutes 75th Percentile Intra-Svc Time: 90 minutes
 Low: 30 minutes High: 150 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>45 minutes</u>	<u>3 visits</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
52237	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method); with lithotripsy	7.97
52601	Transurethral electro-surgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	11.51

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above

RATIONALE

50590

Please refer to attached "Expanded Rationale".

Expanded Rationale
Re: 50590 Lithotripsy, Extracorporeal Shockwave

Workgroup 3 Discussion

- Although Workgroup 3 agreed with the AUA's contention that lithotripsy requires surgical like qualifications, the American Lithotripsy Society (ALS) study was not compelling enough to convince the group to recommend an increase in work value. The workgroup suggested that the AUA conduct a survey of lithotripsy and present the results to the full RUC Committee.
- The Carrier Medical Directors commented that lithotripsy is "not a surgical procedure. Intra-service work is comparable to one hour of critical care. Added to this are two hospital visits (99221 and 99231) and 2.5 level three office visits. This procedure also needs to be revalued to take into account the change in technology over the past 5 - 6 years and the apparent increase in technician time vis-a-vis physician time."
- The AUA rebutted CMD's comments as follows:

Lithotripsy is performed in the operating room, and anesthesiologist administers anesthesia to the patient. The urologist is always present and must have full operating room credentials. The urologist cannot leave the operating room during the procedure.

Most urologists use lithotripters that require the patient be under general or epidural anesthesia; this represents "old" technology. Newer lithotripters, or lithotripters where anesthesia is not needed, still require that the patient be heavily sedated. These "new" technology machines require up to twice as many shockwaves and take up to twice the amount of time as the older machines.

There has been no decrease in the urologist's involvement in the procedure in the past 11 years. The urologist is still present throughout the procedure as are the technical support staff i.e., nurses, radiologic technologists, nursing assistants, surgical technicians, etc.

American Lithotripsy Society (ALS) Survey

- In response to a request from HCFA in 1993, the American Lithotripsy Society (ALS) asked The Moore Group to perform a detailed analytical survey of the experience of shock wave lithotripsy providers in the U.S. for FY 1992. The ALS, the primary manufacturers of lithotripters, and other sources sent a survey to every site. Roughly 31% returned the completed survey. The surveys were "blinded" in that they were sent to counsel for the ALS who then provided the information to the survey group. The data in this summary is limited to the direct physicians activity in provision of

SWL services for that year and encompasses 52,401 treatments.

- Study data collection: The times associated with ESWL were taken from hospital and anesthesia records. Data was not collected by opinion surveys.
- HCFA made the following assumptions regarding the lithotripsy procedure (Federal Register Vol. 58, No 189, Friday, October 1, 1993, Notices at p. 51359):
 - (1) It takes a urologist 30 minutes to perform the actual lithotripsy procedure;
 - (2) A provider could perform six treatments per day allowing a maximum of 80 minutes per treatment
 - (3) 80 minutes includes:
 - (a) preparing patient for treatment,
 - (b) treatment time,
 - (c) time preparing the procedure room between treatments and
 - (d) recovery room time
- The ALS study, a review of 52,401 medical records, found the following:
 - (1) mean treatment time is 112.9 minutes,
 - (2) shortest treatment time 50 minutes,
 - (3) longest treatment time 345 minutes. HCFA's estimate of a 30-minute treatment time is over 18 standard deviations from the mean.
 - (4) mean pre-treatment time 37 minutes
 - (5) mean post-treatment time 105 minutes

AUA August, 1995 RUC Survey

See attached survey where respondents were asked the type of lithotripter they most commonly used. 28 respondents used "old" technology (range of respondents' RVW 3.01 to 12.00) 17 respondents used "new" technology (range of respondents' RVW 12.00 to 20.00)

Conclusion

The ALS and AUA surveys and the above discussion establishes compelling evidence for an increase in RVW to 11.00.

CMD Comments30-Jun-95

Code: 50590**1995 RVUs:** 9.62**Recommended RVUs:** 6.54**Ratio:** -0.32**Long Descriptor:** Lithotripsy, extracorporeal shock wave**Reference Set (y/n):** N**Global Period:** 090**Frequency:** 28,932**Impact:** -89110.56**Source:** 1**Year:** 92**Public Comment Letter:****Reference Services:**

	Short Descriptor	RVU	Global
50590			
	99213 OFFICE/OUTPATIENT VISIT, EST	0.55	XXX
	99221 INITIAL HOSPITAL CARE	1.06	XXX
	99231 SUBSEQUENT HOSPITAL CARE	0.51	XXX
	99291 CRITICAL CARE, FIRST HOUR	3.64	XXX

CMD Comment:

Not a surgical procedure. Intraservice work is comparable to one hour of critical care. Added to this are two hospital visits (99221 and 99231) and 2.5 level 3 office visits. This procedure also needs to be revalued to take into account the change in technology over the past 5-6 years and the apparent increase in technician time vis-a-vis physician time.

Societies Wishing to Survey: AUA**Societies Wishing to Comment:****Trends Analysis -- Beneficiary Information:**

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50590	32.2	4.3	7.1	38.6	13	0.3	0.4	13

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50590	27499	30368	5.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50590	22.6	15.7	-3.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50590		
	group practices	3.5
	urology	95.5

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

	ICD9	Pct of Time Used	ICD9 Descriptor
50590			
	592	25.2	CALCULUS OF KIDNEY AND URETER
	599	1.3	OTHER DISORDERS OF URETHRA AND U

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50590							
CMD		090	090	9.53	9.62	1.01	9.62

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50590								
CMD	9.62	9.62	1.01	1.00	1.00	1.00	6.54	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
50590								
CMD	090	9.53		30		66		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50590									
CMD		0.5		10	0.0		0	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
50590									
CMD		15		6.54	9.62	ur	n		0.105

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50684

CPT Code: 50684 Global Period: 090 Source: HCFA assigned (1992 only)

Current RVW: .76 CMD Recommended RVW: .50 AUA Survey RVW: .75

Medicare Frequency: 3,006 Proposed reduction: 34% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *This is a procedure of such low intensity and effort that it will rarely be done by physicians. It does not compare with effort and skill of indirect laryngoscopy.*

Reference code(s) used by CMD:

31505 - Laryngoscopy, indirect (separate procedure); diagnostic (RVW 0.61)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year old woman with a uric acid stone has had a percutaneous nephrostolithotomy.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work

Urologist meets patient in the radiology department, the patient is positioned and a scout film is taken. Contrast is injected under fluoroscopy through the previously placed ureterostomy tube, filling defects are found in the mid ureter and films are taken.

Description of Post-Service Work

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 94% (74/79) Median RVW: .75

25th Percentile RVW: .55 75th Percentile RVW: 1.21 Low: .45 High: 7.00

Median Pre-Service Time: 20 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 30 minutes
 Low: 5 minutes High: 60 minutes

50684

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>15 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	74400	Urography (pyelography), intravenous, with or without KUB, with or without tomography	.49
2)	53670	Catheterization, urethra; simple	.50
3)	76872	Echography, transrectal	.69

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

- 1) Time - key reference procedures are similar in time
- 2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 2 of 5
Technical skill and physical effort	Median response 2 of 5
Psychological stress	Median response 1 of 5

The Carrier Medical Directors' (CMD) comment that "this is a procedure of such low intensity and effort that it will rarely be done by physicians" is totally incorrect. **In fact, this procedure is almost always done by the urologist.** This is most commonly done to assess stone fragments in the ureter after percutaneous stone removal (50081). The patient has a ureterostomy tube or a nephrostomy tube in place, contrast is injected and the urologist then views the fluoroscopy unit to determine if stones are present. He must also then determine the approach to be taken to remove the stones. The assumption that this is "rarely done by physicians" is grossly inaccurate and demonstrates a lack of understanding of how stone disease is treated.

Interestingly, the survey's results of .75 are essentially the same as the current RVW of 0.76

Conclusion: The current value of 0.76 should be maintained or if HCFA wishes to reduce this to the AUA survey result of 0.75 that would be acceptable.

CMD Comments

30-Jun-95

Code: 50684

1995 RVUs: 0.76

Recommended RVUs: 0.50

Ratio: -0.34

Long Descriptor: Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter

Reference Set (y/n): N **Global Period:** 000 **Frequency:** 3,006 **Impact:** -781.56

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
50684			
	31505 DIAGNOSTIC LARYNGOSCOPY	0.61	000

CMD Comment:

This is a procedure of such low intensity and effort that it will rarely be done by physicians. It does not compare with effort and skill of indirect laryngoscopy.

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50684	46.4	5.8	8.7	50.7	11.6	0	0	9.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50684	2927	3354	7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50684	48.1	48.6	0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50684		
	group practices	2.5
	radiology	25.6
	urology	70.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
50684			
	188	3.6	MALIGNANT NEOPLASM OF BLADDER

CMD Comments

30-Jun-95

591	2.9	HYDRONEPHROSIS
592	4	CALCULUS OF KIDNEY AND URETER
593	2.9	OTHER DISORDERS OF KIDNEY AND UR
595	1.8	CYSTITIS
597	1.8	URETHRITIS, NOT SEXUALLY TRANSMIT
599	9.1	OTHER DISORDERS OF URETHRA AND U
789	2.2	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50684							
CMD		ZZZ	000	1.00	0.76	0.76	0.76

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50684								
CMD	0.76	0.76	0.76	1.00	1.00	1.00	0.50	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
50684								
CMD	000	1.00		11	*	18		8

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
50684									
CMD	*	0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
50684									
CMD		0		0.50	0.76	ur	3		0.031

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

50715

CPT Code: 50715 Global Period: 000 Source: HCFA Refinement panel:
increased value
Current RVW: 17.60 CMD Recommended RVW: 14.00 AUA Survey RVW: 17.60
Medicare Frequency: 1,329 Proposed reduction: 20% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *It's incorrect to value this procedure higher than 50700 - revision of ureter. It is comparable to 50080 - removal of stone at 14.14. It is not as difficult as 50780 - ureteroneocystostomy which has a value of 17.31.*

Reference code(s) used by CMD:

50700 - Ureteroplasty, plastic operation on ureter (e.g. stricture) (RVW 14.10)

50780 - Ureteroneocystostomy; anastomosis of single ureter to bladder (RVW 17.12)

50080 - Nephrostolithotomy; under 2 cm (RVW 13.98)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old man with vague left flank pain is found to have obstruction of the mid 12 centimeters of the left ureter by a retroperitoneal mass. A left ureteral stent has been previously placed.

Description of Pre-Service Work

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) Communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation and evaluation at which the decision to provide the procedure was made.

Description of Intra-Service Work

A midline abdominal incision is made. The left colon is reflected medially, the left ureter is identified just below the renal pelvis. The mid left ureter is encased in dense fibrotic tissue. Frozen sections are compatible with the diagnosis of idiopathic retroperitoneal fibrosis without malignancy. The ureter is gradually mobilized and then freed from the dense retroperitoneal tissue, the ureter is then positioned laterally and intraperitoneally. The incision is closed.

Description of Post-Service Work

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

SURVEY DATA:

50715

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 96% (76/79) Median RVW: 17.50

25th Percentile RVW: 16.50 75th Percentile RVW: 19.00 Low: 15 High: 27.00

Median Pre-Service Time: 60 minutes Median Intra-Service Time: 135 minutes

25th Percentile Intra-Svc Time: 120 minutes 75th Percentile Intra-Svc Time: 180 minutes

Low: 80 minutes High: 300 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>100 minutes</u>	<u>6 visits</u>
Office:	<u>60 minutes</u>	<u>3 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	50725	Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava	17.12
2)	50620	Ureterolithotomy, middle one-third of ureter	14.17
3)	50400	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple	18.07

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - similar in time to reference procedure 50725

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 4 of 5
Technical skill and physical effort	Median response 4 of 5
Psychological stress	Median response 4 of 5

The Carrier Medical Directors' (CMD) comments are based on a lack of knowledge of urologic surgery and comparison of this procedure to procedures that are unrelated. Virtually any urologist would comment that 50715 is much more difficult than 50700. 50700, "ureteroplasty, plastic operation of the ureter, eg stricture," is a **normal** ureter lying in **normal** tissue with a narrow spot that must be excised or treated in some such manner.

A "ureterolysis" involves a ureter which is encased in cancer or scar tissue from the renal pelvis typically to the iliac vessels and is a very challenging, long, difficult operation. The CMDs compared this to 50080 a "percutaneous nephrostolithotomy", an endoscopic procedure done with laparoscopic instruments through the flank, which has no relationship to an open surgical procedure.

The survey data is tight. The 25th percentile RVW is 16.50 and the 75th percentile RVW is 19.00.

In addition this CPT code went through HCFA refinement and was assigned a value of 17.60. It seems unreasonable that HCFA would allow this code to be questioned again since its value has already been validated through its own refinement process.

Conclusion: The current RVW of 17.60 is appropriate. The AUA survey is astoundingly close at 17.50. In additional support of this conclusion, one merely needs to compare key reference services chosen by the urologists and compare them to those chosen by the CMDs.

CMD Comments

30-Jun-95

Code: 50715

1995 RVUs: 17.6

Recommended RVUs: 14

Ratio: -0.20

Long Descriptor: Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis

Reference Set (y/n): N

Global Period: 090

Frequency: 1,329

Impact: -4784.4

Source: 5

Year: 93

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
50715			
	50080 REMOVAL OF KIDNEY STONE	13.98	090
	50700 REVISION OF URETER	14.10	090
	50780 REIMPLANT URETER IN BLADDER	17.12	090

CMD Comment:

This code is incorrect valued higher than 50700. It is comparable to 50080 (removal of stone) at 14.14. It is not as difficult as 50780 (ureteroneocystostomy) with a value of 17.31.

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACOG

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
50715	46.7	6.7	13.3	86.7	11.1	0	0	6.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
50715	1536	1650	3.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
50715	95.4	94.3	-0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
50715		
	general surgery	17.1
	group practices	3.5
	obstetrics/gynecology	39.2
	urology	37

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

	ICD9	Pct of Time Used	ICD9 Descriptor
50715			
	016	1.1	TUBERCULOSIS OF GENITOURINARY SY
	182	1.1	MALIGNANT NEOPLASM OF BODY OF U
	183	7.2	MALIGNANT NEOPLASM OF OVARY AND
	568	2.2	OTHER DISORDERS OF PERITONEUM
	591	1.7	HYDRONEPHROSIS
	593	9.4	OTHER DISORDERS OF KIDNEY AND UR
	614	2.2	INFLAMMATORY DISEASE OF OVARY, F
	789	2.2	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
50715							
CMD		090	090	17.30	17.60	1.02	16.12

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
50715								
CMD	17.60	17.60	0.93	1.09	1.00	1.00	14.00	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
50715								
CMD	090	17.30		35		148		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
50715									
CMD		1.0	*	10	7.0		10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
50715									
CMD		15		14.00	17.60	ur	3		0.079

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51010

CPT Code: 51010 Global Period: 010 Source: Harvard
Current RVW: 2.54 CMD Recommended RVW: 1.75 AUA Survey RVW: 3.24
Medicare Frequency: 14,441 Proposed reduction: 31% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Aspiration of bladder; with insertion of suprapubic catheter

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *This procedure is not as difficult in technical skills and training as is 31622- bronchoscopy at 2.83 RVWs. It is much closer to 47000 - biopsy of liver; percutaneous, which has a work value of 1.92.*

Reference code(s) used by CMD:

31622 - Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing (RVW 2.80)

47000 - Biopsy of the liver; percutaneous (RVW 1.90)

51000 - Aspiration of bladder by needle (RVW 0.78)

51005 - Aspiration of bladder by trocar or intracatheter (RVW 1.02)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year old man is admitted to the ICU with congestive heart failure and given diuretics. His bladder is distended, the urologist is unable to get a catheter or filiform through the urethra into the bladder. There is a lower abdominal scar from previous colon resection.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work

A stab wound on the lower abdomen is made 1 cm above the pubis with the tip of a scalpel, a trocar suprapubic tube is inserted into the bladder, the balloon is inflated and the tube is sutured into place, 1200 of clear urine is immediately obtained.

Description of Post-Service Work

Some of the following **may** be included: (1) all post-procedure care on the day of the procedure, **and if applicable** – patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other follow-up care before the patient is discharged; (2) all post-procedure hospital visits and office visits for this procedure for **10 days** after the day of the procedure are considered part of the post-operative work for this procedure (including evaluation of laboratory reports and medication adjustment)

Three (level 2) follow-up ICU visits are made make sure that the catheter is functioning properly and has not

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 96% (76/79) Median RVW: 3.24

25th Percentile RVW: 2.00 75th Percentile RVW: 4.88 Low: 1.20 High: 12.00

Median Pre-Service Time: 32.5 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 20 minutes 75th Percentile Intra-Svc Time: 37.5 minutes

Low: 10 minutes High: 90 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20 minutes</u>	
ICU:	<u>30 minutes</u>	<u>3 visits</u>
Other Hospital:	<u>20 minutes</u>	<u>2 visits</u>
Office:	<u>15 minutes</u>	<u>1 visit</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	36489	Placement of central venous catheter (subclavian, jugular, or other vein) (e.g. central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	1.22
2)	52000	Cystourethroscopy (separate procedure)	2.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures are similar in time

2) Intensity - key reference procedures are less intense

Mental effort and judgement Median response 3 of 5

Technical skill and physical effort Median response 3 of 5

Psychological stress Median response 3 of 5

The Carrier Medical Directors' (CMD) comment, that "This procedure is not as difficult in technical skills and training as is 31622 - bronchoscopy at 2.83 RVWs. It is much closer to 47000 - biopsy of liver, percutaneous which has a work value of 1.92."

The lack of understanding of the setting used or the problem involved will become apparent by reading the vignette and description of intra-service work.

Bronchoscopy and biopsy of the liver are scheduled procedures – done at the convenience of the physician. This is an emergency procedure performed when the referring physician or nursing staff is unable to pass a urethral catheter – most commonly in an elderly male – and a suprapubic catheter must be put in as a life-saving procedure. Therefore, these procedures are done often at night, on the weekends or by interrupting one's office hours to go to the hospital to perform the procedure. There is significant risk involved because many of these patients have had lower abdominal surgery or have an ileus.

The survey data suggests an RVW of 3.24, AUA has felt for years that this procedure is undervalued because of its technical skill and emergent nature, however, we have used restraint in bringing this to the RUC for an increase in RVW.

Conclusion: The current RVW of 2.54 is inappropriately low and this **should be increased** to the survey result of 3.24. There is absolutely no rationale whatsoever to justify the CMD reduction to 1.75. Review of the vignette and description of intra-service work which describe the typical patient confirm this.

CMD Comments

30-Jun-95

Code: 51010

1995 RVUs: 2.54

Recommended RVUs: 1.75

Ratio: -0.31

Long Descriptor: Aspiration of bladder, with insertion of suprapubic catheter

Reference Set (y/n): N Global Period: 010 Frequency: 14,441 Impact: -11408.39

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51010			
	31622 DIAGNOSTIC BRONCHOSCOPY	2.80	000
	47000 NEEDLE BIOPSY OF LIVER	1.90	000
	51000 DRAINAGE OF BLADDER	0.78	000
	51005 DRAINAGE OF BLADDER	1.02	000

CMD Comment:

This procedure is not as difficult in technical skills and training as is 31622 (bronchoscopy) with 2.83. It is much closer to 47000 (biopsy of liver percutaneous) with a value of 1.92.

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACEP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51010	52.6	12.5	9.2	50	6.5	0.3	0.9	12.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51010	14312	15548	4.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51010	66.8	66.6	-0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51010		
	general surgery	3.7
	general/family practice	3
	group practices	3.2
	obstetrics/gynecology	17
	urology	68.9

CMD Comments

30-Jun-95

Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
51010		
185	1.5	MALIGNANT NEOPLASM OF PROSTATE
596	1.3	OTHER DISORDERS OF BLADDER
598	2	URETHRAL STRICTURE
599	2.3	OTHER DISORDERS OF URETHRA AND U
600	2.1	HYPERPLASIA OF PROSTATE
618	9.2	GENITAL PROLAPSE
625	4.9	PAIN AND OTHER SYMPTOMS ASSOCIAT
788	9	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51010							
CMD		010	010	1.91	2.54	1.33	2.54

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
51010								
CMD	2.54	2.54	1.33	1.00	1.00	1.00	1.75	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
51010								
CMD	010	1.91		13		17		16

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
51010									
CMD		0.0		0	0.0		0	0.0	1.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51010									
CMD		15		1.75	2.54	ur	3		0.048

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51597

CPT Code: 51597 Global Period: 090 Source: Refinement panel: retain published value
Current RVW: 35.27 CMD Recommended RVW: 32.25 AUA Survey RVW: 35.27
Medicare Frequency: 482 Proposed reduction: 9% Harvard (Dunn) RUC Analysis: Code identified as overvalued not

CPT Descriptor: Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *The large difference between this code and 58240 - pelvic exenteration, female is due to a difference of over two hours in estimated intra-service time in the Harvard Study. There is probably very little real difference in work, so the most practical step would be to average the codes and assign the same RVW to both.*

Reference code(s) used by the CMD:

58240 - Pelvic exenteration, female (RVW 28.79)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old man has biopsy-proven sarcoma of the bladder invading through to the rectum. The Tumor Board has recommended a pelvic exenteration.

Description of Pre-Service Work

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation and evaluation at which the decision to provide the procedure was made.

Central arterial and venous lines are placed. The patient is under continuous epidural and general endotracheal anesthesia. The patient is positioned supine, and slightly flexed, with the foot of the table down and the legs apart in Allen leg holders. The patient is shaved and prepped from the nipples to the mid thighs including the genitalia, perineum and anal areas.

Description of Intra-Service Work

A midline abdominal incision is made and the Bookwalter retractor system is used. An exploratory laparotomy is done to rule out metastatic cancer, the liver and other intra-abdominal organs are normal, there is no palpable or visible adenopathy along the great vessels. The small bowel is mobilized onto the abdomen and placed in a Lehey Bag. The large tumor mass involving the bladder and rectum is easily palpated.

The left colon is mobilized and divided leaving a distal stump of sigmoid colon to be included with the surgical specimen. A bilateral pelvic lymphadenectomy is done, including external iliac, hypogastric and obturator nodes. All remaining fatty tissue is dissected down toward the bladder along with the stump of colon. The vessels and nerves in the pelvis are skeletonized, great care is taken to protect the ileoinguinal and genitofemoral nerves. The ureters are identified, clipped near the bladder, divided and tagged; frozen section

The prostate is mobilized, the puboprostatic ligaments are divided, the dorsal venous complex is tied and divided, the urethra is divided, the lateral vascular pedicles of the bladder are mobilized, tied and divided.

Attention is directed to the perineum. The anus is mobilized from below with electrosurgical unit. The posterior aspect of the rectum is mobilized taking a wide margin. The specimen is mobilized and removed as one unit consisting of bladder, prostate, anus, rectum and a portion of sigmoid colon.

Significant bleeding in the pelvis is noted. Time is taken to achieve good hemostasis in the huge pelvic defect with multiple surgical clips, suture ligatures and the electrosurgical unit. The perineal defect is closed as best as possible from below by bringing levator muscles together. The skin is reapproximated.

A colostomy is created in standard fashion.

NOTE: *The urinary diversion (ureterocolon conduit, ureteroileal conduit, or continent diversion) portion of the operation is billed separately and is not included as part of the work for this procedure.*

After the urinary diversion is completed, abdominal, retroperitoneal and perineal drains are placed. The abdomen is closed.

Description of Post-Service Work

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

After the patient is stable in the recovery room, he is transferred to the ICU still intubated and on the ventilator. The patient spends three days in the ICU and 12 days in the hospital.

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 95% (75/79) Median RVW: 35.00

25th Percentile RVW: 34.00 75th Percentile RVW: 40.00 Low: 26.73 High: 50.55

Median Pre-Service Time: 90 minutes Median Intra-Service Time: 300 minutes

25th Percentile Intra-Svc Time: 240 minutes 75th Percentile Intra-Svc Time: 360 minutes

Low: 180 minutes High: 720 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>60 minutes</u>	
ICU:	<u>90 minutes</u>	<u>4.5 visits</u>
Other Hospital:	<u>180 minutes</u>	<u>12 visits</u>
Office:	<u>90 minutes</u>	<u>5 visits</u>

KEY REFERENCE SERVICE(S):

51597

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	51595	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	34.25
2)	55845	Prostatectomy, retropubic radical, with or without nerve sparing, with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	26.73

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures are similar in time

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 5 of 5
Technical skill and physical effort	Median response 5 of 5
Psychological stress	Median response 5 of 5

RATIONALE

The Carrier Medical Directors' (CMD) compare this procedure to the female pelvic exenteration but it is a cavalier statement to say "the most practical step would be to average the codes and assign the same RVW to both codes."

This huge operation in either a male or female, is one of the most technically demanding and stressful operations in the surgical armamentarium.

The vignette and description of intra-service work are self explanatory.

The AUA survey revealed an RVW of 35.00, astoundingly similar to the current RVW of 35.27. In addition, these patients spend an average of 4.5 days in the ICU and have extreme fluid and electrolyte management problems.

Conclusion: The current RVW of 35.27 is confirmed by the AUA's survey. The CMD rationale of "averaging two different codes should be rejected by the RUC and HCFA and both codes should have an RVW of 35.27.

CMD Comments

30-Jun-95

Code: 51597

1995 RVUs: 35.27

Recommended RVUs: 32.25

Ratio: -0.09

Long Descriptor: Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 482 **Impact:** -1455.64

Source: 4 **Year:** 93 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
51597			
	58240 REMOVAL OF PELVIS CONTENTS	28.79	090

CMD Comment:

The large difference between this code and pelvic exenteration, female (58240) is due to a difference of over two hours in estimated intraservice time in the Harvard study. There is probably very little real difference in work, so the most practical step would be to average the codes and assign the same RVU to both.

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACOG

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51597	62.5	12.5	12.5	75	0	0	0	12.5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51597	603	548	-4.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51597	96.7	97.1	0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51597		
	general surgery	19.2
	group practices	4.4
	urology	68.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51597			

CMD Comments

30-Jun-95

185	3.1	MALIGNANT NEOPLASM OF PROSTATE
188	25	MALIGNANT NEOPLASM OF BLADDER
619	3.1	FISTULA INVOLVING FEMALE GENITAL

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
S1597							
CMD		090	090	37.00	35.27	0.95	35.27

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
S1597								
CMD	35.27	35.27	0.95	1.00	1.00	1.00	32.25	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
S1597								
CMD	090	37.00		51		454		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
S1597									
CMD		1.5		15	13.5		10	3.5	4.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
S1597									
CMD		15		32.25	35.27	ur	3		0.056

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51600

CPT Code: 51600 Global Period: 000 Source: HCFA Assigned (1992 only)

Current RVW: .88 CMD Recommended RVW: .50 AUA Survey RVW: .90

Medicare Frequency: 34,372 Proposed reduction: 43% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Injection procedure for cystography or voiding urethrocytography

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *This procedure is more comparable to 46600 - Anoscopy, which has an RVW of .50. This procedure is overvalued compared to other diagnostic procedures. The work involved is less than the 58100 - endometrial biopsy, whose RVW is .71 and 45300 - Proctosigmoidoscopy, whose RVW is .70.*

Reference codes used by CMD:

45300 - Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (RVW 0.70)

58100 - Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (RVW 0.71)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old woman with chronic urinary tract infections and stress urinary incontinence with a history of two previous operations for urinary incontinence.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work

A number 16 Foley catheter is placed. The bladder is filled with contrast under fluoroscopy. The catheter is removed and the patient voids in the upright position. A video recording is made.

Description of Post-Service Work

Some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

SURVEY DATA:

51600

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 97% (77/79) Median RVW: .90

25th Percentile RVW: .60 75th Percentile RVW: 1.85 Low: .10 High: 4.50

Median Pre-Service Time: 20 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 30 minutes

Low: 4 minutes High: 50 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>15 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	53670	Catheterization, urethra; simple	.50
2)	52000	Cystourethroscopy (separate procedure)	2.01
3)	76872	Echography, transrectal	.69

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - requires less time than a cystoscopy and more time than a catheterization.

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 2 of 5
Technical skill and physical effort	Median response 2 of 5
Psychological stress	Median response 1 of 5

RATIONALE

51600

The Carrier Medical Directors' (CMD) comment that "This procedure is more comparable to 46600 - anoscopy which has an RVW of 0.50. This procedure is overvalued compared to other diagnostic procedures."

The CMDs have compared procedures in one specialty with procedures in other specialties in which the CMDs have no expertise and little knowledge. It is noted that anoscopy and proctosigmoidoscopy are procedures that are done at the physician's convenience **in the office setting or in an exam room**. Our procedure, 51600, must be scheduled in a radiology, fluoroscopic suite. Often times the urologist does indeed perform this procedure, evaluating the elderly patient with urinary incontinence. It is important for the urologist to view the dynamic process of voiding for the correct interpretation and choice of treatment. **This procedure has been incorrectly compared to procedures that are performed in the office.**

Conclusion: The AUA survey RVW is appropriately close to the current RVW of 0.88 which should be maintained. It would be inappropriate, and grossly unfair to reduce this procedure by the flawed logic presented to 0.50.

CMD Comments

30-Jun-95

Code: 51600 1995 RVUs: 0.88 Recommended RVUs: 0.50 Ratio: -0.43

Long Descriptor: Injection procedure for cystography or voiding urethrocytography

Reference Set (y/n): N Global Period: 000 Frequency: 34,372 Impact: -13061.36

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51600			
45300	PROCTOSIGMOIDOSCOPY	0.70	000
58100	BIOPSY OF UTERUS LINING	0.71	000

CMD Comment:

It is more comparable to anoscopy (code 46600, RVU = 0.5). This procedure is overvalued compared to other diagnostic procedures. The work involved is less than the endometrial biopsy (code 58100, RVU = 0.71) and proctosigmoidoscopy (code 45300, RVU = 0.7).

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACEP, ACR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51600	40.9	9.7	12.8	45.5	10.9	3.5	3	10.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51600	38811	37260	-2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51600	34	31.4	-1.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51600		
	group practices	4
	radiology	62.7
	urology	30.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51600			
	185	1.3	MALIGNANT NEOPLASM OF PROSTATE

CMD Comments

30-Jun-95

593	1.7	OTHER DISORDERS OF KIDNEY AND UR
596	2.6	OTHER DISORDERS OF BLADDER
599	4.7	OTHER DISORDERS OF URETHRA AND U
600	1.4	HYPERPLASIA OF PROSTATE
788	5.4	SYMPTOMS INVOLVING URINARY SYST
789	2.1	OTHER SYMPTOMS INVOLVING ABDOM
V72	5.7	SPECIAL INVESTIGATIONS AND EXAMIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51600							
CMD		ZZZ	000	1.02	0.88	0.86	0.88

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
51600								
CMD	0.88	0.88	0.86	1.00	1.00	1.00	0.50	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
51600								
CMD	000	1.02		10	*	15		8

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
51600									
CMD	*	0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51600									
CMD		0		0.50	0.88	ur	3		0.039

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51610

CPT Code: 51610 Global Period: 000 Source: Harvard
Current RVW: 1.59 CMD Recommended RVW: .90 AUA Survey RVW: 1.05
Medicare Frequency: 8,327 Proposed reduction: 43% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Injection procedure for retrograde urethrocytography

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *A reduction would bring this service in alignment with this family of codes. Proportionate reduction to 51600. (See also 51600)*

Reference codes used by CMD:

45300 - Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (RVW 0.70)

58100 - Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (RVW 0.71)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year old man with a history of chronic urethral stricture disease refractory to office dilation is being evaluated for urethral stricture surgery.

Description of Pre-Service Work:

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work:

The patient is obliqued on the x-ray table by the urologist, the four prongs of a Brodney penile clamp are applied to the end of the penis which is then stretched and the injection tip is inserted into the urethral meatus. A bolus of contrast is injected into the urethra and an x-ray is exposed.

Description of Post-Service Work:

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

SURVEY DATA:

51610

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 99% (78/79) Median RVW: 1.05

25th Percentile RVW: .64 75th Percentile RVW: 1.66 Low: .49 High: 6.00

Median Pre-Service Time: 20 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 30 minutes Low: 2 minutes High: 60 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>15 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	53670	Catheterization, urethra; simple	.50
2)	52000	Cystourethroscopy (separate procedure)	2.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures are similar in time

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 2 of 5
Technical skill and physical effort	Median response 2 of 5
Psychological stress	Median response 1 of 5

Y

RATIONALE

51610

The Carrier Medical Directors' (CMD) comment that this procedure should be brought into alignment with the "family of codes", once again demonstrates the lack of understanding of what is being performed. This procedure is almost never done by a technician or a radiologist but is usually done by a urologist in the radiology suite. The description of intra-service work describes what is actually involved when performing this procedure.

The AUA survey RVWs are 1.05 compared to the current RVW of 1.59.

Conclusion: The AUA survey indicates that this procedure could be reduced to 1.05 RVWs.

CMD Comments

30-Jun-95

Code: 51610

1995 RVUs: 1.59

Recommended RVUs: 0.90

Ratio: -0.43

Long Descriptor: Injection procedure for retrograde urethrocytography

Reference Set (y/n): N

Global Period: 000

Frequency: 8,327

Impact: -5745.63

Source: 1

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51610			
	45300 PROCTOSIGMOIDOSCOPY	0.70	000
	58100 BIOPSY OF UTERUS LINING	0.71	000

CMD Comment:

This brings this into correct alignment with this family of codes. Proportionate reduction to 51600 (see above).

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACEP, ACR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51610	42.6	8.3	17.8	26.5	11.7	1.3	1.3	10.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51610	9306	9244	-0.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51610	32.8	30.1	-1.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51610		
	group practices	3.6
	radiology	41.1
	urology	52.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51610			
	185	3.2	MALIGNANT NEOPLASM OF PROSTATE

CMD Comments

30-Jun-95

592	2.1	CALCULUS OF KIDNEY AND URETER
593	1.3	OTHER DISORDERS OF KIDNEY AND UR
598	3.3	URETHRAL STRICTURE
599	6.3	OTHER DISORDERS OF URETHRA AND U
600	2.1	HYPERPLASIA OF PROSTATE
788	3.8	SYMPTOMS INVOLVING URINARY SYST
V72	3	SPECIAL INVESTIGATIONS AND EXAMIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51610							
CMD		ZZZ	000	1.34	1.59	1.19	1.59

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
51610								
CMD	1.59	1.59	1.19	1.00	1.00	1.00	0.90	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
51610								
CMD	000	1.34		18		14		16

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
51610									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51610									
CMD		0		0.90	1.59	ur	3		0.041

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51700

CPT Code: 51700 Global Period: 000 Source: HCFA Assigned (1992 only)
Current RVW: .88 CMD Recommended RVW: .50 AUA Survey RVW: 1.00
Medicare Frequency: 61,498 Proposed reduction: 43% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Bladder irrigation, simple, lavage and/or instillation

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *A reduction would bring this service's work value in line with other work values in this family of codes. This procedure is comparable to 51600 and should be valued the same.*

Reference codes used by CMD:

51600 - Injection procedure for cystography or voiding urethrocytography (RVW 0.88)

46600 - Anoscopy, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (RVW 0.50)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old woman with a long history of a female urethral syndrome and interstitial cystitis is treated with DMSO.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work

A number 16 Foley catheter is placed and the bladder is drained. 50 CCs of DMSO is placed in the bladder and the catheter is clamped for 15 minutes. The bladder is then drained and the catheter is removed.

Description of Post-Service Work

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

SURVEY DATA:

51700

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 100% Median RVW: 1.00

25th Percentile RVW: .65 75th Percentile RVW: 1.5 Low: .49 High: 3.50

Median Pre-Service Time: 15 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 30 minutes
Low: 5 minutes High: 50 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>10 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	53670	Catheterization, urethra; simple	.50
2)	52000	Cystourethroscopy (separate procedure)	2.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures are similar in time

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 2 of 5
Technical skill and physical effort	Median response 1 of 5
Psychological stress	Median response 1 of 5

RATIONALE

51700

The Carrier Medical Directors' (CMD) comment that this procedure should be compared to 51600 (cystogram) is inappropriate. 51600 is a radiologic procedure performed for diagnosis of urinary incontinence. 51700 is a therapeutic procedure performed in the office. The vignette and description of intra-service work presented is self explanatory.

The AUA survey result of 1.00 is similar to the current RVW of 0.88. The woman with interstitial cystitis, presented in this vignette, is typical. These patients are usually not charged for an office visit unless there is a separately identifiable E&M service performed. These are very unhappy, miserable patients and it is noted in the description of post-service work that all communication with the patient and family is included in this RVW.

Conclusion: The present RVW of 0.88 is appropriate and should be maintained. There is no justification for a 43% reduction in this therapeutic code. The CMDs have inappropriately compared this to a **diagnostic** radiologic procedure and a **diagnostic** anoscopy.

CMD Comments

30-Jun-95

Code: 51700

1995 RVUs: 0.88

Recommended RVUs: 0.50

Ratio: -0.43

Long Descriptor: Bladder irrigation, simple, lavage and/or instillation

Reference Set (y/n): N

Global Period: 000

Frequency: 61,498

Impact: -23369.24

Source: 2

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51700			
46600	DIAGNOSTIC ANOSCOPY	0.50	000
51600	INJECTION FOR BLADDER X-RAY	0.88	000

CMD Comment:

This brings this in line with the other values in this family of codes. This procedure is comparable to 51600 and should be valued the same.

Societies Wishing to Survey:

Societies Wishing to Comment: ACEP, ASC, AUA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51700	51.1	11.4	9.2	62.7	7.1	0	0.7	11.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51700	65188	64024	-0.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51700	6	5.6	-0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51700	urology	94.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51700	185	1.2	MALIGNANT NEOPLASM OF PROSTATE
	188	2.7	MALIGNANT NEOPLASM OF BLADDER
	595	11.7	CYSTITIS

CMD Comments

30-Jun-95

596	1.2	OTHER DISORDERS OF BLADDER
598	1.9	URETHRAL STRICTURE
599	5.4	OTHER DISORDERS OF URETHRA AND U
600	1.6	HYPERPLASIA OF PROSTATE
788	4.7	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51700							
CMD		ZZZ	000	1.02	0.88	0.86	0.88

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
51700								
CMD	0.88	0.88	0.86	1.00	1.00	1.00	0.50	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
51700								
CMD	000	1.02		9		16		9

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
51700									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51700									
CMD		0		0.50	0.88	ur	3		0.037

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51720

CPT Code: 51720 Global Period: 000 Source: Harvard
Current RVW: 1.96 CMD Recommended RVW: 1.01 AUA Recommended RVW: 1.96
Medicare Frequency: 148,446 Proposed reduction: 48% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Bladder instillation of anticarcinogenic agent (including retention time)

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *This procedure involves the same amount of time but less skill and intensity than thoracentesis. Increment over 51700 should be no more than that of 62289 - injection into spinal canal, or over 62270 - spinal tap (0.51 RVWs)*

Reference code(s) used by CMD:

51700 - Bladder irrigation, simple, lavage and/or instillation (RVW 0.88)

62270 - Spinal puncture, lumbar, diagnostic (RVW 1.13)

62289 - Injection of substance other than anesthetic, contrast, or neurolytic solutions; lumbar or caudal epidural (separate procedure) (RVW 1.64)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year old man is four weeks post-op TUR of a noninvasive transitional carcinoma of the bladder. He is a candidate for BCG therapy.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work

Following OSHA guidelines for the reconstitution and administration of BCG, gown, gloves, protective eyewear and a face mask must be worn. The bladder is catheterized and drained of urine, 50 CCs of BCG is placed in the bladder and the catheter is removed. The catheter, gown, gloves, mask and all equipment used are disposed of in accordance with OSHA regulations. The patient is asked to position himself periodically on his right, left, abdomen and back to make sure that all areas of the bladder are treated during the course of two hours. The patient then voids all of the material from his bladder into the toilet.

Description of Post-Service Work

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

SURVEY DATA:

51720

Specialty: DID NOT SURVEY

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____

Low: _____ High: _____

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure: _____

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
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RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The Carrier Medical Directors (CMD) state that this procedure requires less skill and intensity than thoracentesis. This statement is unsupported by any documentation or attempt at scientific survey evaluation.

The CMDs then state that the incremental difference between 51720 should be the same as the incremental difference between 62270 and 62289. Having, in the CMDs' analysis, incorrectly reduced 51700 (substantiated by the preceding argument with that particular code) they then added 0.51 RVWs, the difference between the spinal codes and added to 0.50 to come up with 1.01.

It is difficult to refute this illogical argument. The AUA did not survey this code because as explained in the executive summary, an discussion of what is involved in this service is sufficient.

Bladder cancer is very common in the Medicare population. It is most commonly associated with a long history of cigarette abuse.

Urologists have become entangled in OSHA regulations for dealing with BCG, the anti- cancer agent that is used when treating non invasive transitional cell bladder cancer (which constitutes 80% of those individuals with bladder cancer).

BCG is not a benign drug. It may reactivate long dormant TB, result in significant hematuria and bladder pain can be a management problem in these patients. It is further noted that this is not an "XXX" code, but rather a **000 code** global period which means all services provided prior, during and following the procedure, on the day of the procedure are included in this current RVW of 1.96.

Furthermore, the urologist grapples with OSHA guidelines when dealing with BCG. For years urologists were able to safely deal with BCG without the current restrictive OSHA guidelines, however now, the catheter, gown, gloves, masks and all equipment used must be done in accordance with OSHA regulations which increases the time and hassle factor. Many of these patients have significant irritative bladder symptoms. They are often on the telephone when not in the office and the physician must deal with these symptoms. Likewise, the day of the treatment the patient often experiences bladder pain and hematuria which must be dealt with by the urologist -- all of these services being included in the current RVW of 1.96.

"Chemotherapy administration" CPT codes (CPT 1995 pg. 336) - The family of CPT codes for "chemotherapy administration includes four codes:

	RVW	PC	PLI	Total
CPT 96440 - Chemo admin into pleural cavity, including thoracentesis	2.37	.81	.06	3.24
CPT 96445- Chemo admin into peritoneal cavity, including peritoneocentesis	2.20	.98	.09	3.27
CPT 51720 - Bladder instillation of anticarcinogenic agent (including dention time)	1.96	.45	.05	2.46
CPT 96450- Chemo admin into CNS (intrathecal, including lumbar puncture	1.89	.87	.06	2.82

Clearly code 51720 "fits" where CPT has placed it. Also, clearly, the "Practice Cost" component is much too low. 51720 has a practice cost component which is 50% of the other codes which are usually done in the

hospital and involve therefore NO cost of equipment or supplies.

Conclusion: Treatment of elderly patients with bladder cancer is not simple. The CMD- recommended RVW of 1.10 is arrived at through a flawed rationale based upon incorrect suppositions, nonexistent data and a comparison between procedures which are totally unrelated – a **diagnostic** spinal procedure compared to a **therapeutic** procedure involving anti-cancer drugs. The AUA recommendation is that this procedure stay at the current RVW of 1.96. This, at first glance, may seem high but, once made aware of what is involved in supplying this therapy to the Medicare population (85% of all bladder cancer patients) hopefully, it is understood that this is indeed a "bargain" at 1.96 units.

96414 infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump

(For pump or reservoir refilling, see 96520, 96530)

96420 Chemotherapy administration, intra-arterial; push technique

96422 infusion technique, up to one hour

96423 infusion technique, one to 8 hours, each additional hour

96425 infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump

(For pump or reservoir refilling, see 96520, 96530)

96440 Chemotherapy administration into pleural cavity, requiring and including thoracentesis

96445 Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis

96450 Chemotherapy administration, into CNS (eg, intrathecal), requiring and including lumbar puncture

(For intravesical (bladder) chemotherapy administration, see 51720)

(For insertion of subarachnoid catheter and reservoir for infusion of drug, see 63750, 63780; for insertion of intraventricular catheter and reservoir, see 61210, 61215)

(96500-96512 have been deleted. To report, see 96408-96414)

96520 Refilling and maintenance of portable pump

(96524, 96526 have been deleted. To report, see 96420-96425)

96530 Refilling and maintenance of implantable pump or reservoir

(Access of pump port is included in filling of implantable pump)

(96535 has been deleted. To report, see 96440, 96445)

(96540 has been deleted. To report, see 96542)

96542 Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents

96545 Provision of chemotherapy agent

(For radioactive isotope therapy, see 79000-79999)

96549 Unlisted chemotherapy procedure

Special Dermatological Procedures

Dermatologic services are typically consultative, and any of the five levels of consultation (99241-99263) may be appropriate.

In addition, services and skills outlined under Evaluation and Management levels of service appropriate to dermatologic illnesses should be coded similarly.

(For intralesional injections, see 11900, 11901)

(For Tzanck smear, use 87207)

96900 Actinotherapy (ultraviolet light)

96910 Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B

96912 psoralens and ultraviolet A (PUVA)

96913 Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least four to eight hours of care under direct supervision of the physician (includes application of medication and dressings)

96999 Unlisted special dermatological service or procedure

Physical Medicine and Rehabilitation

(97000 has been deleted. To report, use 97010-97039)

(For muscle testing, range of joint motion, electromyography, see 95831 et seq)

CMD Comments

30-Jun-95

Code: 51720

1995 RVUs: 1.96

Recommended RVUs: 1.01

Ratio: -0.48

Long Descriptor: Bladder instillation of anticarcinogenic agent (including detention time)

Reference Set (y/n): N Global Period: 000 Frequency: 148,446 Impact: -141023.7

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51720			
51700	IRRIGATION OF BLADDER	0.88	000
62270	SPINAL FLUID TAP, DIAGNOSTIC	1.13	000
62289	INJECTION INTO SPINAL CANAL	1.64	000

CMD Comment:

This procedure involves the same amount of time but less skill and intensity than thoracentesis. Increment over 51700 should be no more than that of 62289 over 62270 (0.51 RVUs).

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51720	53.1	12.5	3.3	29	2.7	0.3	0.3	12

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51720	147158	159012	3.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51720	0.9	0.4	-0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51720	urology	95.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51720	188	20	MALIGNANT NEOPLASM OF BLADDER
	233	1.7	CARCINOMA IN SITU OF BREAST AND G

CMD Comments

30-Jun-95

595	1.5	CYSTITIS
599	1.3	OTHER DISORDERS OF URETHRA AND U

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51720							
CMD		ZZZ	000	0.93	1.96	2.11	1.96

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
51720								
CMD	1.96	1.96	2.11	1.00	1.00	1.00	1.01	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ftime	Notett	Imppt
51720								
CMD	000	0.93		12		27		6

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
51720									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51720									
CMD		0		1.01	1.96	ur	3		0.019

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51725

CPT Code: 51725 Global Period: 000 Source: HCEA Assigned (1992 only)

Current RVW: 1.51 CMD Recommended RVW: 1.10 AUA Survey RVW: 1.80

Medicare Frequency: 26,700 Proposed reduction: 27% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Simple cystometrogram (CMG) (e.g., spinal manometer)

Source and Summary of Comment to HCEA on this service: Carrier Medical Director comment. *This procedure is overvalued compared to other diagnostic procedures. The work is no more than 85095 - bone marrow aspiration or 31575 - laryngoscopy.*

Reference codes used by CMD:

85095 - Bone marrow; aspiration only (RVW 1.08)

31575 - laryngoscopy, flexible fiberoptic; diagnostic (RVW 1.10)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 66-year old woman complains of urinary frequency, and urgency with residual urine of 120 ml.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Calibrate electronic equipment. Insert urodynamic catheter and measure post-void residual urine. Attach fluid bag to spinal manometer and three-way stop clock. Purge all air bubbles from tubing. Connect catheter to infusion pump.

Description of Intra-Service Work

This is an interactive examination between patient and examiner. The procedural steps vary considerably depending upon the cystometric findings. Infuse fluid into bladder and record bladder sensations and bladder volume at predefined physiologic landmarks. Each rise in vesical pressure must be accounted for by careful observations. If involuntary detrusor contractions are not demonstrated, assist patient to sitting and/or standing position and repeat infusion. Check patient for stress incontinence.

Description of Post-Service Work

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable; (3) interpret results.

SURVEY DATA:

51725

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 90% (71/79) Median RVW: 1.80

25th Percentile RVW: 1.25 75th Percentile RVW: 2.25 Low: .52 High: 4.00

Median Pre-Service Time: 20 minutes Median Intra-Service Time: 25 minutes

25th Percentile Intra-Svc Time: 20 minutes 75th Percentile Intra-Svc Time: 30 minutes Low: 10 minutes High: 60 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>15 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	53670	Catheterization, urethra; simple	.50
2)	52000	Cystourethroscopy (separate procedure)	2.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures are similar in time to 52000

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 3 of 5
Technical skill and physical effort	Median response 2 of 5
Psychological stress	Median response 1 of 5

The Carrier Medical Directors' (CMD) comment that "This procedure is overvalued compared to other diagnostic procedures. The work is no more than 85095-bone marrow aspiration or 31575 - laryngoscopy." Once again, these are cross-specialty comparisons that bare absolutely no relevance to the procedure in question. The error at this point throws all of the other urodynamic codes into disarray. By way of commenting, a bone marrow aspiration takes only a few minutes, a flexible laryngoscopy in the doctor's office takes less than one minute; however, our argument is not based on these facts.

In understanding that there is nothing "simple" about a "simple cystometrogram", in fact, some would argue that this is more complex than the so called "complex cystometrogram". Many urodynamic purists feel that this is a more accurate procedure which uses a spinal manometer and water. The pre and intra-service work descriptions illustrate an interactive relationship between the physician and the patient.

Global period is '000'. This means that all services provided the day of the service, including the procedure and all post procedure care including communication with the patient and family are included in the RVW. **The CMDs have compared this to 85095 bone marrow, aspiration only; which is an "XXX" global period.** There is a great difference between the global concept of XXX vs 000. The XXX means an office visit or any other code can be billed on the same day and that the RVWs are for the procedure only and none of the pre and post work.

The AUA survey indicated an RVW of 1.80, the current RVW is 1.51.

Conclusion: The CMD recommendation is flawed because of a misunderstanding of what the procedure involves and an overlooking of the different types of global periods. The code should be maintained at its current value of 1.51 or possibly increased to 1.80.

CMD Comments

30-Jun-95

Code: 51725 1995 RVUs: 1.51 Recommended RVUs: 1.10 Ratio: -0.27

Long Descriptor: Simple cystometrogram (CMG) (eg, spinal manometer)

Reference Set (y/n): N Global Period: 000 Frequency: 26,700 Impact: -10947

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51725			
	31575 DIAGNOSTIC LARYNGOSCOPY	1.10	000
	85095 BONE MARROW ASPIRATION	1.08	XXX

CMD Comment:

This procedure is overvalued compared to other diagnostic procedures. The work is no more than a bone marrow aspiration (code 85095, RVU 1.05) or laryngoscopy (code 31575, RVU 1.1).

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACOG

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51725	50.1	12.2	8.1	62.5	7.3	0.1	0.3	10.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51725	29657	28769	-1.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51725	23.7	17	-3.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51725		
	obstetrics/gynecology	5.4
	urology	88.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51725			
	344	2.3	OTHER PARALYTIC SYNDROMES
	595	1.5	CYSTITIS

CMD Comments

30-Jun-95

596	3.4	OTHER DISORDERS OF BLADDER
599	4.7	OTHER DISORDERS OF URETHRA AND U
600	3.5	HYPERPLASIA OF PROSTATE
618	1.6	GENITAL PROLAPSE
625	5.4	PAIN AND OTHER SYMPTOMS ASSOCIAT
788	11.1	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51725							
CMD	26		000		1.51		1.51
CMD		ZZZ	000	1.40	1.51	1.08	1.51

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
51725								
CMD	1.51	1.51		1.00	1.00	1.00	1.10	
CMD	1.51	1.51	1.08	1.00	1.00	1.00	1.10	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
51725								
CMD	000	1.40		12		27		10

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
51725									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51725									
CMD		0		1.10	1.51	ur	3		0.032

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51726

CPT Code: 51726 Global Period: 000 Source: Harvard
Current RVW: 1.71 CMD Recommended RVW: 1.25 AUA Survey RVW: 1.71
Medicare Frequency: 108.521 Proposed reduction: 27% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Complex cystometrogram (e.g., calibrated electronic equipment)

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *This brings this into correct alignment with this family of codes. Proportionate reduction to 51725 (see 51725)*

Reference codes used by CMD:

85095 - Bone marrow, aspiration only (RVW 1.08)

31575 - laryngoscopy, flexible fiberoptic; diagnostic (RVW 1.10)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 66-year old woman complains of urinary frequency, and urgency with residual urine of 120 ml.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Calibrate electronic equipment. Insert urodynamic catheter and measure post-void residual urine. Connect catheter to infusion pump and pressure transducer and zero transducer to atmospheric pressure. Purge air from tubing.

Description of Intra-Service Work

This is an interactive examination between patient and examiner. The procedural steps vary considerably depending upon the cystometric findings. Infuse fluid into bladder and record bladder sensations and bladder volume at predefined physiologic landmarks. Each rise in vesical pressure must be accounted for by careful observations. If involuntary detrusor contractions are not demonstrated, assist patient to sitting and/or standing position and repeat infusion. Check patient for stress incontinence.

Description of Post-Service Work

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable. (3) interpret results.

SURVEY DATA:

51726

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 92% (73/79) Median RVW: 2.00

25th Percentile RVW: 1.50 75th Percentile RVW: 3.00 Low: .20 High: 5.00

Median Pre-Service Time: 25 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 20 minutes 75th Percentile Intra-Svc Time: 45 minutes

Low: 10 minutes High: 75 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>15 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	53670	Catheterization, urethra; simple	.50
2)	52000	Cystourethroscopy (separate procedure)	2.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

- 1) Time - similar in time to reference procedure 52000.
- 2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 3 of 5
Technical skill and physical effort	Median response 2 of 5
Psychological stress	Median response 1 of 5

RATIONALE

The Carrier Medical Directors (CMD) comments are in error because of a lack of understanding of the steps involved in the pre, intra and post work of a complex cystometrogram. (see vignette and description of work)

Based on the flawed reasoning for 51725, the CMDs suggested reducing the code by 27%.

Conclusion: The AUA survey recommends an RVW of 2.00. The AUA recommends to retain the current RVW of 1.71.

CMD Comments

30-Jun-95

Code: 51726 **1995 RVUs:** 1.71 **Recommended RVUs:** 1.25 **Ratio:** -0.27

Long Descriptor: Complex cystometrogram (eg, calibrated electronic equipment)

Reference Set (y/n): N **Global Period:** 000 **Frequency:** 108,521 **Impact:** -49919.66

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
51726			
	31575 DIAGNOSTIC LARYNGOSCOPY	1.10	000
	85095 BONE MARROW ASPIRATION	1.08	XXX

CMD Comment:

This brings this into correct alignment with this family of codes. Proportionate reduction to 51725 (see above).

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACOG

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51726	48.2	10.2	9.7	57.4	9.9	0.2	0.5	9.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51726	114500	116470	0.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51726	20.1	16.2	-1.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51726		
	group practices	2.3
	obstetrics/gynecology	5.2
	urology	89.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51726			
	344	3.3	OTHER PARALYTIC SYNDROMES

CMD Comments

595	1	CYSTITIS
596	3.9	OTHER DISORDERS OF BLADDER
599	2.8	OTHER DISORDERS OF URETHRA AND U
600	3.4	HYPERPLASIA OF PROSTATE
618	1.3	GENTAL PROLAPSE
625	4.1	PAIN AND OTHER SYMPTOMS ASSOCIAT
788	11.5	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51726							
CMD		ZZZ	000	1.39	1.71	1.23	1.71

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
51726								
CMD	1.71	1.71	1.23	1.00	1.00	1.00	1.25	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
51726								
CMD	000	1.39		15		29		10

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
51726									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51726									
CMD		0		1.25	1.71	ur	n		0.030

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51741

CPT Code: 51741 Global Period: 000 Source: Harvard
Current RVW: 1.57 CMD Recommended RVW: 1.14 AUA Recommended RVW: 1.57
Medicare Frequency: 229,207 Proposed reduction: 27% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Complex uroflowmetry (e.g., calibrated electronic equipment)

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *This brings this into correct alignment with this family of codes. Proportionate reduction to 51725 (see 51725)*

Reference codes used by CMD:

85095 - Bone marrow, aspiration only (RVW 1.08)
31575 - laryngoscopy, flexible fiberoptic; diagnostic (RVW 1.10)

CLINICAL DESCRIPTION OF SERVICE:

Vignette: 73-year old man with symptoms of prostatism.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Instruct patient on how to use flowmeter. Calibrate and check flowmeter.

Description of Intra-Service Work

Patient voids into flowmeter

Description of Post-Service Work

Some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable; (3) interpret results.

Question patient about the flow to determine if he voided in his usual fashion.

SURVEY DATA: DID NOT SURVEY

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

51741

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____
Low: _____ High: _____

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	_____	_____
ICU:	_____	_____
Other Hospital:	_____	_____
Office:	_____	_____

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
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RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

RATIONALE

51741

Carrier Medical Directors' (CMD) comments are incorrect. This has been reduced 27% on the basis of the flawed thinking for the simple cystometrogram. It should be noted that this is a 000 global period, not an ~~XXX~~ global period.

Conclusion: The AUA recommends retaining the current RVW of 1.57.

CMD Comments

30-Jun-95

Code: 51741

1995 RVUs: 1.57

Recommended RVUs: 1.14

Ratio: -0.27

Long Descriptor: Complex uroflowmetry (eg, calibrated electronic equipment)

Reference Set (y/n): N Global Period: 000 Frequency: 229,207 Impact: -98559.01

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51741			
	31575 DIAGNOSTIC LARYNGOSCOPY	1.10	000
	85095 BONE MARROW ASPIRATION	1.08	XXX

CMD Comment:

This brings this into correct alignment with this family of codes. Proportionate reduction to 51725 (see above).

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACOG

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51741	41.8	6	10.6	14.4	5.5	0.1	0.2	9.2

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
51741	208773	245252	8.4

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51741	2.1	1.3	-0.4

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
51741	urology	95.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51741	185	2	MALIGNANT NEOPLASM OF PROSTATE
	596	3.2	OTHER DISORDERS OF BLADDER
	598	1.2	URETHRAL STRICTURE

CMD Comments

30-Jun-95

599	3.5	OTHER DISORDERS OF URETHRA AND U
600	13.3	HYPERPLASIA OF PROSTATE
625	1	PAIN AND OTHER SYMPTOMS ASSOCIAT
788	7.3	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51741							
CMD		ZZZ	000	1.64	1.57	0.96	1.57

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
51741								
CMD	1.57	1.57	0.96	1.00	1.00	1.00	1.14	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
51741								
CMD	000	1.64		13		28		13

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
51741									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51741									
CMD		0		1.14	1.57	ur	3		0.038

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51772

CPT Code: 51772 Global Period: 000 Source: Harvard
Current RVW: 1.61 CMD Recommended RVW: 1.17 AUA Survey RVW: 1.61
Medicare Frequency: 19,529 Proposed reduction: 27% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *This brings this into correct alignment with this family of codes. Proportionate reduction to 51725 (see 51725)*

Reference code(s) used by CMD:

85095 - Bone marrow, aspiration only (RVW 1.08)

31575 - laryngoscopy, flexible fiberoptic; diagnostic (RVW 1.10)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 66-year old woman complains of urinary stress incontinence 6 months after undergoing an anti-incontinence operation.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Calibrate electronic equipment. Insert urodynamic catheter and measure post-void residual urine. Connect catheter to infusion pump, pressure transducer and catheter puller. Zero transducer to atmospheric pressure. Purge air from tubing.

Description of Intra-Service Work

This is an interactive examination between patient and examiner. The procedural steps vary considerably depending upon the cystometric findings. Infuse fluid and begin to withdraw catheter through the urethra and record bladder sensations and bladder volume at predefined physiologic landmarks. Each rise in urethral pressure must be accounted for by careful observations and annotated. If involuntary detrusor contractions occur, evidenced by voiding around the catheter, the bladder should be emptied. In some instances, the examination needs to be repeated in the sitting and/or standing position. When intra-urethral pressure is at its maximum, then have patient do sustained Valsalva maneuver and several coughs and record changes to urethral pressures.

Description of Post-Service Work

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable; (3) interpret results.

SURVEY DATA:

51772

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 77% (61/79) Median RVW: 1.75

25th Percentile RVW: 1.11 75th Percentile RVW: 2.50 Low: .30 High: 4.50

Median Pre-Service Time: 20 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 30 minutes

Low: 5 minutes High: 60 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>15 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	53670	Catheterization, urethra; simple	.50
2)	52000	Cystourethroscopy (separate procedure)	2.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures are similar in time

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 2 of 5
Technical skill and physical effort	Median response 2 of 5
Psychological stress	Median response 1 of 5

RATIONALE

51772

The Carrier Medical Directors' (CMD) comment compared this procedure to a simple cystometrogram, urethral pressure profile. There is no similarity between the two procedures. The flawed rationale of reducing this procedure 27% is inappropriate.

This is a 000 global period which includes all of the services on the day of the procedure, the procedure itself and all of the post service work. An "XXX" globe for bone marrow aspiration is for the procedure only. The AUA's survey suggests a RVW of 1.75.

Conclusion: The AUA's recommendation is to maintain the current RVW of 1.61.

CMD Comments

30-Jun-95

Code: 51772 1995 RVUs: 1.61 Recommended RVUs: 1.17 Ratio: -0.27

Long Descriptor: Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique

Reference Set (y/n): N Global Period: 000 Frequency: 19,529 Impact: -8592.76

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51772			
	31575 DIAGNOSTIC LARYNGOSCOPY.	1.10	000
	85095 BONE MARROW ASPIRATION	1.08	XXX

CMD Comment:

This brings this into correct alignment with this family of codes. Proportionate reduction to 51725 (see above).

Societies Wishing to Survey: AUA

Societies Wishing to Comment: ACOG

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51772	40.6	6.9	9.7	64.6	11.6	0	0.2	8.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51772	19494	21138	4.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51772	11.9	8.7	-1.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51772		
	group practices	3.7
	obstetrics/gynecology	19.5
	urology	73.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51772			
	344	2.4	OTHER PARALYTIC SYNDROMES

CMD Comments

30-Jun-95

596	3.3	OTHER DISORDERS OF BLADDER
599	2.1	OTHER DISORDERS OF URETHRA AND U
600	2.1	HYPERPLASIA OF PROSTATE
618	2.1	GENTIAL PROLAPSE
625	6.3	PAIN AND OTHER SYMPTOMS ASSOCIAT
788	11.5	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51772							
CMD		ZZZ	000	1.61	1.61	1.00	1.61

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
51772								
CMD	1.61	1.61	1.00	1.00	1.00	1.00	1.17	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
51772								
CMD	000	1.61		17		26		6

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
51772									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51772									
CMD		0		1.17	1.61	ur	3		0.042

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51785

CPT Code: 51785 Global Period: 000 Source: RUC reviewed 1994
Current RVW: 1.53 Recommended RVW: .42 AUA Survey RVW: 1.53
Medicare Frequency: 53.658 Proposed reduction: 73% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Needle electromyography studies (EMG) of anal or urethral sphincter, any technique

Source and Summary of Comment to HCFA on this service:

Carrier Medical Director comment: *Interpretation only. Comparable to EMG of extrocular muscles, 92265 RVW .081.*

Reference Procedures used by CMD:

	<u>Global Period</u>
92265 EMG of extrocular muscles (0.81 RVW)	XXX

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

35- year old man with spinal cord injury presents with a voiding dysfunction. One or two needles ae placed in the pelvic floor muscles (external sphincter) to determine whether the muscles arecoordinated during filling and voiding. The urologist reads the graphic recordings measuring EMG activity during a series of filling and voiding trials. He/she interprets the level of activity and determines whether the muscle activity is increasing and decreasing at appropriate times.

Description of Pre-Service Work:

see vignette

Description of Intra-Service Work:

see vignette

Description of Post-Service Work:

see vignette

SURVEY DATA:

Specialty: American Urological Association

Sample Size: 50 Response Rate (%): 58% Median RVW: 1.55

25th Percentile RVW: 1.54 75th Percentile RVW: 1.74 Low: .70 High: 3.20

Median Pre-Service Time: 10 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 10 minutes 75th Percentile Intra-Svc Time: 50 minutes Low: 5 minutes
High: 60 minutes

Median Post-Service Time:	<u> </u>	<u> </u>
Day of Procedure:	<u> </u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u> </u>	<u> </u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	1.53
2)	51726	Complex cystometrogram	1.73

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

- 1) Time - key reference procedures are similar in time
- 2) Intensity - key reference procedures are similar in intensity

RATIONALE

This service has already been through the RUC process in 1994. The result was a unanimous vote for the current work value

Also, the CMDs used an XXX procedure as a reference code rather than a 000.

Conclusion:

Retain the current RVW of 1.53

CMD Comments

30-Jun-95

Code: 51785

1995 RVUs: 1.53

Recommended RVUs: 0.42

Ratio: -0.73

Long Descriptor: Needle electromyography studies (EMG) of anal or urethral sphincter, any technique

Reference Set (y/n): N Global Period: 000 Frequency: 53,658 Impact: -59560.38

Source: 11 Year: 94 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51785			
	92265 EYE MUSCLE EVALUATION	0.81	XXX

CMD Comment:

Interpretation only. Comparable to EMG of extraocular muscles (code 92265, RVU 0.81).

Societies Wishing to Survey: AUA

Societies Wishing to Comment: AAPMR, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51785	51.5	13	7.9	65.7	8.8	0.3	0.9	6.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51785	46680	58894	12.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51785	16.8	11.1	-2.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51785		
	general surgery	2.5
	internal medicine	6.2
	obstetrics/gynecology	6.7
	other nonphysician prov	4.2
	urology	73.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51785			

CMD Comments

344	2.6	OTHER PARALYTIC SYNDROMES
596	2.7	OTHER DISORDERS OF BLADDER
599	1.9	OTHER DISORDERS OF URETHRA AND U
600	1.6	HYPERPLASIA OF PROSTATE
625	3.1	PAIN AND OTHER SYMPTOMS ASSOCIAT
728	4.8	DISORDERS OF MUSCLE, LIGAMENT, AN
788	11.8	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51785							
CMD		ZZZ	000	1.57	1.53	0.97	1.53

Harvard Data:

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
51785								
CMD	1.53	1.53	0.97	1.00	1.00	1.00	0.42	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
51785								
CMD	000	1.57		14		30		14

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
51785									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51785									
CMD		0		0.42	1.53	ur	3		0.031

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51792

CPT Code: 51792 Global Period: 000 Source: Harvard
Current RVW: 1.10 CMD Recommended RVW: .59 AUA Survey RVW: 1.10
Medicare Frequency: 929 Proposed reduction: 46% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Stimulus-evoked response (e.g., measurement of bulboca- vernosus reflex latency time)

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment.
Interpretation only. Comparable to 95935 - "H" or "F" reflex study, by electrodiagnostic testing. The procedure is less extensive than 95925 - Somatosensory testing (e.g. cerebral-evoked potentials), one or more nerves (because 95925 typically involves testing more nerves).

Reference codes used by CMD:

95935 - "H" or "F" reflex study, by electrodiagnostic testing (RVW 0.59)

95925 - Somatosensory testing (e.g. cerebral-evoked potentials), one or more nerves (RVW 0.81)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 65-year old male complaining of impotence with known diabetes mellitus and mild Parkinsonism.

Description of Pre-Service Work:

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. **Attach multiple electrodes to the penis and anus.** Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work:

Stimulate penis and record all results of bulbocavernosis reflex latency time. Repeat this procedure a minimum of ten (10) times.

Description of Post-Service Work:

Some of the following **may** apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

Print out report and explain results to the patient.

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 100% Median RVW: 1.20

25th Percentile RVW: .75 75th Percentile RVW: 2.15 Low: .40 High: 3.50
Median Pre-Service Time: 15 minutes Median Intra-Service Time: 20 minutes

51792

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 30 minutes
Low: 5 minutes High: 60 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>10 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52000	Cystourethroscopy (separate procedure)	2.01
2)	76872	Echography, transrectal	.69

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

- 1) Time - key reference procedures are similar in time
- 2) Intensity - key reference procedures are similar in intensity
Mental effort and judgement Median response 2 of 5
Technical skill and and physical effort Median response 2 of 5
Psychological stress Median response 1 of 5

RATIONALE

51792

The Carrier Medical Directors (CMD) compare this to electro-diagnostic testing. This is inappropriate. We find it hard to believe that the CMDs had a true familiarity with this procedure. The AUA is in complete disagreement that our procedure is less extensive than 95925. Also, this code is of very low frequency being billed only 929 in one year. This would mean that only one out of every nine urologists does this procedure once a year.

The global period for 51792 is 000, which means that all services provided the day of the procedure, the procedure itself and all after service work (explaining procedure and results to the patient and family) are included in the RVW. In contrast, the reference procedures 95925 and 95935 are both XXX global period procedures. The work values for these procedures do not include any of the pre service work or post service work performed that day and the physician can bill additionally for any other services involved.

The AUA survey of 1.20 is extremely close to the current RVW of 1.10.

Conclusion: The AUA recommends maintaining the current RVW of 51792 at 1.10.

CMD Comments

30-Jun-95

Code: 51792

1995 RVUs: 1.1

Recommended RVUs: 0.59

Ratio: -0.46

Long Descriptor: Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)

Reference Set (y/n): N Global Period: 000 Frequency: 929 Impact: -473.79

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51792			
	95925 SOMATOSENSORY TESTING	0.81	XXX
	95935 "H" OR "F" REFLEX STUDY	0.59	XXX

CMD Comment:

Interpretation only. Comparable to 95935. The procedure is less extensive than 95925 as 95925 typically involves testing more nerves.

Societies Wishing to Survey: AUA

Societies Wishing to Comment: AAPMR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51792	22.2	0	22.2	44.4	27.8	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51792	914	936	1.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51792	10.5	10.7	0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51792		
	general surgery	2.4
	group practices	5.6
	obstetrics/gynecology	14.5
	rehabilitation medicine	12.6
	urology	62.4

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

	ICD9	Pct of Time Used	ICD9 Descriptor
51792			
	211	2.8	BENIGN NEOPLASM OF OTHER PARTS O
	344	2.8	OTHER PARALYTIC SYNDROMES
	355	2.8	MONONEURITIS OF LOWER LIMB AND U
	569	2.8	OTHER DISORDERS OF INTESTINE
	607	8.3	DISORDERS OF PENIS
	728	2.8	DISORDERS OF MUSCLE, LIGAMENT, AN
	787	5.6	SYMPTOMS INVOLVING DIGESTIVE SYS
	788	2.8	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51792							
CMD		ZZZ	000	1.34	1.10	0.82	1.10

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
51792								
CMD	1.10	1.10	0.82	1.00	1.00	1.00	0.59	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
51792								
CMD	000	1.34		10	*	13		9

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
51792									
CMD	*	0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
51792									
CMD	*	0		0.59	1.10	ur	3		0.071

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51795

CPT Code: 51795 Global Period: 000 Source: Harvard
Current RVW: 1.53 Recommended RVW: 1.11 AUA Survey RVW: 1.53
Medicare Frequency: 24,154 Proposed reduction: 27% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Voiding pressure studies (VP); bladder voiding pressure, any technique

Source and Summary of Comment to HCFA on this service: *This brings this into correct alignment with this family of codes. Proportionate reduction to 51725 (see also 51725)*

Reference code(s) used by CMD:

85095 - Bone marrow; aspiration only (RVW 1.08)

31575 - laryngoscopy, flexible fiberoptic; diagnostic (RVW 1.10)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 69-year old man complains of urinary frequency, urgency, weak stream and a post void residual urine of 210 ml.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Calibrate electronic equipment. Insert urodynamic catheter and measure post-void residual urine. Connect catheter to infusion pump and pressure transducer and zero transducer to atmospheric pressure. Purge air from tubing.

Description of Intra-Service Work

This is an interactive examination between patient and examiner. The procedural steps vary considerably depending upon the cystometric findings. Infuse fluid into bladder and record bladder sensations and bladder volume at predefined physiologic landmarks. Ask the patient to try to void when he feels full. Each rise in vesical pressure must be accounted for by careful observations to distinguish detrusor contractions from rises in abdominal pressure.

If detrusor contractions are not demonstrated, assist patient with provocative maneuvers such as turning on running water or helping him relax. If still unable to void, terminate the examination.

Description of Post-Service Work

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable; (3) interpret results

SURVEY DATA:

51795

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 100% Median RVW: 2.00

25th Percentile RVW: 1.22 75th Percentile RVW: 2.75 Low: .50 High: 6.00

Median Pre-Service Time: 20 minutes Median Intra-Service Time: 25 minutes

25th Percentile Intra-Svc Time: 20 minutes 75th Percentile Intra-Svc Time: 30 minutes
Low: 5 minutes High: 60 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>15 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	53670	Catheterization, urethra; simple	.50
2)	52000	Cystourethroscopy (separate procedure)	2.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures are similar in time

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 2.5 of 5
Technical skill and physical effort	Median response 2 of 5
Psychological stress	Median response 1 of 5

RATIONALE

The Carrier Medical Directors (CMD) compared 51795 to the cystometrogram and reduced our code 27% to bring this into correct alignment once again using bone marrow aspiration as a reference procedure. 51795 is a 000 global period procedure and bone marrow aspiration is an XXX global period procedure. Understanding the global period difference will explain that all pre, intra and post service work is included in the RVW, whereas the bone marrow aspiration has a globe of XXX and none of that work is included. The physician may bill extra.

The AUA survey results revealed a value of 2.00 RVWs.

Conclusion: The AUA recommends maintaining the current RVW of 1.53.

CMD Comments

30-Jun-95

Code: 51795

1995 RVUs: 1.53

Recommended RVUs: 1.11

Ratio: -0.27

Long Descriptor: Voiding pressure studies (VP); bladder voiding pressure, any technique

Reference Set (y/n): N Global Period: 000 Frequency: 24,154 Impact: -10144.68

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
51795			
31575	DIAGNOSTIC LARYNGOSCOPY	1.10	000
85095	BONE MARROW ASPIRATION	1.08	XXX

CMD Comment:

This brings this into correct alignment with this family of codes. Proportionate reduction to 51725 (see above).

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51795	45.5	10.1	8.1	53.5	9.1	1	0.6	11.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51795	17707	24842	18.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51795	9.1	6.8	-1.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51795		
	group practices	2.4
	obstetrics/gynecology	7.6
	urology	86.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
51795			
	344	2.5	OTHER PARALYTIC SYNDROMES

CMD Comments

30-Jun-95

596	4.9	OTHER DISORDERS OF BLADDER
599	2.9	OTHER DISORDERS OF URETHRA AND U
600	3.5	HYPERPLASIA OF PROSTATE
618	1.5	GENITAL PROLAPSE
625	3.9	PAIN AND OTHER SYMPTOMS ASSOCIAT
788	12.9	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51795							
CMD		ZZZ	000	1.94	1.53	0.79	1.53

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
51795								
CMD	1.53	1.53	0.79	1.00	1.00	1.00	1.11	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
51795								
CMD	000	1.94		13	*	27		11

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	leuvis	Offvis
51795									
CMD	*	0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
51795									
CMD	*	0		1.11	1.53	ur	3		0.053

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

51797

CPT Code: 51797 Global Period: 000 Source: Harvard
Current RVW: 1.60 CMD Recommended RVW: 1.17 AUA Survey RVW: 1.60
Medicare Frequency: 17.966 Proposed reduction: 27% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)

Source and Summary of Comment to HCFA on this service: *This brings this into correct alignment with this family of codes. Proportionate reduction to 51725 (see above)*

Reference codes used by CMD:

94010 - Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), and/or maximal voluntary ventilation. (RVW 0.17)

94160 - Vital capacity screening tests; total capacity, with timed forced expiratory volume (state duration), and peak flow rate. (RVW 0.18)

94370 - Determination of airway closing volume, single breath tests (RVW 0.26)

94375 - Respiratory flow volume loop (RVW 0.31)

51797 - Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal) (RVW 1.60)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 69-year old man complains of urinary frequency, urgency, weak stream and a post void residual urine of 210 ml.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Calibrate electronic equipment. Insert urodynamic catheter into bladder and measure post-void residual urine. Insert urodynamic catheter into rectum. Connect urinary urodynamic catheter to infusion pump. Connect both catheters to respective pressure transducers and zero transducers to atmospheric pressure. Purge air from tubing.

Description of Intra-Service Work

This is an interactive examination between patient and examiner. The procedural steps vary considerably depending upon the cystometric findings. Infuse fluid into bladder and record bladder sensations and bladder volume at predefined physiologic landmarks. Ask the patient to try to void when he feels full. Each rise in vesical pressure must be accounted for by careful observations to distinguish detrusor contractions from rises

in abdominal pressure. If detrusor contractions are not demonstrated, assist patient with provocative maneuvers such as turning on running water or helping him relax. If still unable to void, terminate the examination. During study, record intravesical pressure and abdominal pressure (rectal); subtract abdominal pressure recorded from the total intravesical pressure and record the true detrusor pressure during voiding.

Description of Post-Service Work:

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable; (3) interpret results.

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 100% Median RVW: 2.00

25th Percentile RVW: 1.50 75th Percentile RVW: 3.0 Low: .65 High: 6.50

Median Pre-Service Time: 20 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 21.25 minutes 75th Percentile Intra-Svc Time: 40 minutes
Low: 5 minutes High: 60 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>15 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52000	Cystourethroscopy (separate procedure)	2.01
2)	53670	Catheterization, urethra; simple	.50

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures are similar in time

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 3 of 5
Technical skill and physical effort	Median response 2 of 5
Psychological stress	Median response 1 of 5

RATIONALE

51797

The Carrier Medical Directors' (CMD) comment that "the proposed reduction of 27% brings this into correct alignment with this family of codes." This procedure is totally unrelated to a cystometrogram. A review of the intra service work will make this extremely clear. A urodynamic catheter is placed into the rectum, and simultaneous readings are made of the abdominal and voiding pressures, which is completely different than a cystometrogram.

The global period for 51797 is 000. The CMDs have overlooked global periods again. All of the CMD reference procedures, including 94010, 94160, 94370, and 94375 have XXX global periods.

Conclusion: The AUA survey results were 2.00 RVWs. The AUA recommends maintaining the current RVWs at 1.60.

CMD Comments

30-Jun-95

Code: 51797 **1995 RVUs:** 1.6 **Recommended RVUs:** 1.17 **Ratio:** -0.27

Long Descriptor: Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)

Reference Set (y/n): N **Global Period:** 000 **Frequency:** 17,966 **Impact:** -7725.38

Source: 1 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
51797			
51797	INTRAABDOMINAL PRESSURE TEST	1.60	000
94010	BREATHING CAPACITY TEST	0.17	XXX
94160	VITAL CAPACITY SCREENING	0.18	XXX
94370	BREATH AIRWAY CLOSING VOLUME	0.26	XXX
94375	RESPIRATORY FLOW VOLUME LOOP	0.31	XXX

CMD Comment:

This brings this into correct alignment with this family of codes. Proportionate reduction to 51725 (see above).

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
51797	42.1	5.7	10.1	52	13.3	0.9	0.9	5.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
51797	12639	18960	22.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
51797	12.1	9.5	-1.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
51797		
	group practices	2.8
	obstetrics/gynecology	5.5
	rehabilitation medicine	2.9
	urology	85.7

CMD Comments

30-Jun-95

Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
51797		
344	3.3	OTHER PARALYTIC SYNDROMES
596	5	OTHER DISORDERS OF BLADDER
599	2.1	OTHER DISORDERS OF URETHRA AND U
600	2	HYPERPLASIA OF PROSTATE
625	3.6	PAIN AND OTHER SYMPTOMS ASSOCIAT
788	13.3	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
51797							
CMD		ZZZ	000	1.99	1.60	0.80	1.60

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
51797								
CMD	1.60	1.60	0.80	1.00	1.00	1.00	1.17	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
51797								
CMD	000	1.99		13	*	35		11

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
51797									
CMD	*	0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
51797									
CMD	*	0		1.17	1.60	ur	3		0.041

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

52007

CPT Code: 52007 Global Period: 000 Source: HCEA Assigned (1992 only)

Current RVW: 3.02 CMD Recommended RVW: 2.37 AUA Survey RVW: 4.50

Medicare Frequency: 1,276 Proposed reduction: 22% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis

Source and Summary of Comment to HCEA on this service: *Brush biopsy involves negligible work beyond ureteral catheterization; bronchoscopy and GI endoscopy values do not increase in value if brushings are done.*

Reference codes used by CMD:

52005 - Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service (RVW 2.37)

31622 - Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing (RVW 2.80)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year old man with a 100 + pack per year history of cigarette smoking has a filling defect in the upper left ureter.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work

The patient is under general anesthesia. Cystoscopy is performed and the left ureteral orifice is identified and under fluoroscopy, a brush biopsy catheter is positioned (with contrast) at the site of the lesion. After several attempts, small fragments of tissue are obtained and placed in formalin.

Description of Post-Service Work

some of the following **may** apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 78 Response Rate (%): 99% (78/79) Median RVW: 4.50

25th Percentile RVW: 3.84 75th Percentile RVW: 5.50 Low: 2.40 High: 10.50

Median Pre-Service Time: 37.5 minutes Median Intra-Service Time: 45 minutes

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 60 minutes
 Low: 18 minutes High: 120 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52000	Cystourethroscopy (separate procedure)	2.01
2)	52337	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method); with lithotripsy	7.97
3)	52235	Cystourethroscopy with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s) (2 to 5 cm)	5.45

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

- 1) Time - key reference procedures are similar in time
- 2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 3 of 5
Technical skill and physical effort	Median response 3 of 5
Psychological stress	Median response 2 of 5

RATIONALE

52007

The Carrier Medical Directors (CMD) comment states, "Brush biopsy involves negligible work beyond ureteral catheterization; bronchoscopy and GI endoscopy values do not increase in value if brushings are done."

The comparison to bronchoscopy is inappropriate. Bronchoscopy is performed mainly in the physicians' office or the procedure room of an outpatient ASC under local anesthesia.

A brush biopsy of the ureter is done in the operating room under general or spinal anesthesia with a fluoroscopic unit. The description of the patient in pre, intra and post service work for the survey outline this well. For the CMDs to state that this involves "negligible work beyond ureteral catheterization" shows a misunderstanding of the procedure. A ureteral catheter with a small biopsy brush must be positioned under fluoroscopy and repeatedly removed and reinserted and repositioned. The CMDs do not seem to be aware of this which makes their assumptions incorrect.

The AUA survey of 4.50 RVWs and the reference procedures chosen by the surveyees are appropriate.

Conclusion: The AUA recommends increasing RVWs for this procedure to 4.50.

CMD Comments

30-Jun-95

Code: 52007

1995 RVUs: 3.02

Recommended RVUs: 2.37

Ratio: -0.22

Long Descriptor: Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis

Reference Set (y/n): N **Global Period:** 000 **Frequency:** 1,276 **Impact:** -829.4

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
52007			
	31622 DIAGNOSTIC BRONCHOSCOPY	2.80	000
	52005 CYSTOSCOPY & URETER CATHETER	2.37	000

CMD Comment:

Brush biopsy involves negligible work beyond ureteral catheterization; bronchoscopy and GI endoscopy values do not increase in value if brushings are done.

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
52007	40	10	18.4	32.5	5	0	0	10.5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
52007	1527	1418	-3.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
52007	48	44	-2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
52007	urology	94.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
52007			
	188	5.6	MALIGNANT NEOPLASM OF BLADDER
	189	1.3	MALIGNANT NEOPLASM OF KIDNEY AN

CMD Comments

30-Jun-95

233	1.3	CARCINOMA IN SITU OF BREAST AND G
236	1.3	NEOPLASM OF UNCERTAIN BEHAVIOR O
239	2.5	NEOPLASMS OF UNSPECIFIED NATURE
592	1.9	CALCULUS OF KIDNEY AND URETER
598	1.9	URETHRAL STRICTURE
599	8.1	OTHER DISORDERS OF URETHRA AND U

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
52007							
CMD		000	000	4.36	3.02	0.69	3.02

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
52007								
CMD	3.02	3.02	0.69	1.00	1.00	1.00	2.37	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
52007								
CMD	000	4.36		21		48		20

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
52007									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
52007									
CMD		0		2.37	3.02	ur	3		0.069

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

52275

CPT Code: 52275 Global Period: 000 Source: HCFA Assigned (1992 only)

Current RVW: 4.70 CMD Recommended RVW: 4.01 AUA Survey RVW: 4.70

Medicare Frequency: 3,444 Proposed reduction: 15% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Cystourethroscopy, with internal urethrotomy; male

Source and Summary of Comment to HCFA on this service: *The present RVW is nearly double the base cystourethroscopy code. Performance in a male may be more difficult but the difference in work should be as great.*

Reference code(s) used by CMD:

52005 - Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service (RVW 2.37)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 67-year old man with long history of pan-urethral stricture disease.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work

The patient is under general anesthesia. A four French filiform is passed to the bladder. A LeForte sound is passed to the bladder and the strictures are dilated up to 20 French. The Otis urethrotome is inserted into the urethra, opened to 35 French and the blade is withdrawn. The procedure is repeated at 3,6,9 and 12:00. A 22 French Foley catheter is placed to straight drainage.

Description of Post-Service Work

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 100% Median RVW: 4.50

25th Percentile RVW: 3.75 75th Percentile RVW: 5.00 Low: 2.72 High: 7.50

Median Pre-Service Time: 30 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 45 minutes

Low: 15 minutes High: 60 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52283	Cystourethroscopy, with steroid injection into stricture	3.74
2)	52235	Cystourethroscopy with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s)	5.45
3)	52000	Cystourethroscopy (separate procedure) (2 to 5 cm)	2.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures are similar in time

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 3 of 5
Technical skill and physical effort	Median response 3 of 5
Psychological stress	Median response 2 of 5

The Carrier Medical Directors' (CMD) argue that "the present RVW is nearly double the base cystourethroscopy code. Performance in a male may be more difficult, but the difference in work should not be that great." This comment shows a lack of understanding of what is involved. This procedure has nothing to do with a cystourethroscopy. It is done with an instrument that bears no relation whatsoever to a cystoscope. This is done with an Otis Urethrotome which is greatly different than a cystoscope. This is a blind procedure – not a visual procedure.

Furthermore, comparison has been made to the female urethrotomy code. This procedure is rarely indicated or done in women. The CMD rationale is inappropriate and to compare this to a cystoscopy, which is a visual examination of the interior of the bladder is incorrect. This procedure involves cutting scar tissue in the male urethra.

The AUA survey shows an RVW of 4.50, remarkably similar to the current RVW of 4.70.

Conclusion: The AUA recommends maintaining the current RVW of 4.70.

CMD Comments

30-Jun-95

Code: 52275

1995 RVUs: 4.7

Recommended RVUs: 4.01

Ratio: -0.15

Long Descriptor: Cystourethroscopy, with internal urethrotomy; male

Reference Set (y/n): N Global Period: 000 Frequency: 3,444 Impact: -2376.36

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
52275			
	52005 CYSTOSCOPY & URETER CATHETER	2.37	000

CMD Comment:

The present RVU is nearly double the base cystourethroscopy code. Performance in a male may be more difficult but difference should not be as great.

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
52275	46.5	11.1	17.3	0	12.1	0	0	12.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
52275	4142	3774	-4.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
52275	39.8	31.2	-4.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
52275		
	anesthesiology	3
	group practices	2.1
	urology	94.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
52275			
	185	3.8	MALIGNANT NEOPLASM OF PROSTATE
	188	1.8	MALIGNANT NEOPLASM OF BLADDER

CMD Comments

30-Jun-95

593	1	OTHER DISORDERS OF KIDNEY AND UR
596	4	OTHER DISORDERS OF BLADDER
598	14.9	URETHRAL STRICTURE
599	4	OTHER DISORDERS OF URETHRA AND U
600	5.6	HYPERPLASIA OF PROSTATE
788	1.5	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
52275							
CMD		000	000	4.32	4.70	1.09	4.70

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
52275								
CMD	4.70	4.70	1.09	1.00	1.00	1.00	4.01	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
52275								
CMD	000	4.32		19		31		25

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
52275									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
52275									
CMD		0		4.01	4.70	ur	3		0.108

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

52276

CPT Code: 52276 Global Period: 000 Source: HCFA Assigned (1992 only)
Current RVW: 3.93 CMD Recommended RVW: 3.43 AUA Survey RVW: 5.00
Medicare Frequency: 14.720 Proposed reduction: 13% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Cystourethroscopy, with direct vision internal urethrotomy

Source and Summary of Comment to HCFA on this service: *Reduction proportionate to reduction in 52275 (see also 52275)*

Reference code(s) used by CMD:

52005 - Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service (RVW 2.37)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year old man with multiple sclerosis and a neurogenic bladder is on intermittent self catheterization. He has developed a bulbous urethral stricture.

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work

Patient is under general anesthesia. Urethroscopy is done with the 20 French visual urethrotome. A four French ureteral catheter is passed through the stricture. The blade of the urethrotome is used to cut the stricture at 3,6,9 and 12:00. Bleeding is minimal. A number 20 catheter is placed to straight drainage.

Description of Post-Service Work

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

Discharge patient home with catheter.

SURVEY DATA:

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 100% Median RVW: 5.00

25th Percentile RVW: 3.98 75th Percentile RVW: 5.35 Low: 2.97 High: 9.00

Median Pre-Service Time: 30 minutes Median Intra-Service Time: 35 minutes

52276

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 45 minutes
Low: 10 minutes High: 75 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52283	Cystourethroscopy, with steroid injection into stricture	3.74
2)	52235	Cystourethroscopy with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s) (2 to 5 cm)	5.45
3)	52000	Cystourethroscopy (separate procedure)	2.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedure 52235 is similar in time.

2) Intensity - key reference procedures are similar in intensity
Mental effort and judgement Median response 3 of 5
Technical skill and physical effort Median response 3 of 5
Psychological stress Median response 2 of 5

RATIONALE

52276

The Carrier Medical Directors' (CMD) comment that "Reduction proportionate to reduction in 52275 (see also 52275)" is inappropriate. That procedure is a nonvisual, blind procedure. 52276 is a more difficult procedure involving endoscopic equipment, visualization of the stricture and use of video equipment. This takes more skill and is more complex than 52275.

The AUA survey of 5.00 RVWs is appropriate.

Conclusion: The AUA recommends increasing current RVWs from 3.93 to 5.00.

CMD Comments

30-Jun-95

Code: 52276

1995 RVUs: 3.93

Recommended RVUs: 3.43

Ratio: -0.13

Long Descriptor: Cystourethroscopy with direct vision internal urethrotomy

Reference Set (y/n): N Global Period: 000 Frequency: 14,720 Impact: -7360

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
52276			
	52005 CYSTOSCOPY & URETER CATHETER	2.37	000

CMD Comment:

Reduction proportionate to reduction in 52275 (see above)

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
52276	55.7	14.3	20.2	1.2	7.1	0	1	16

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
52276	16419	15920	-1.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
52276	43.1	35.1	-4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
52276	urology	97.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
52276	185	2.7	MALIGNANT NEOPLASM OF PROSTATE
	188	1.2	MALIGNANT NEOPLASM OF BLADDER
	596	6.8	OTHER DISORDERS OF BLADDER
	598	17.3	URETHRAL STRICTURE

CMD Comments

30-Jun-95

599	2.5	OTHER DISORDERS OF URETHRA AND U
600	2.2	HYPERPLASIA OF PROSTATE
788	2.4	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
S2276							
CMD		000	000	3.61	3.93	1.09	3.93

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
S2276								
CMD	3.93	3.93	1.09	1.00	1.00	1.00	3.43	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
S2276								
CMD	000	3.61		20		32		25

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
S2276									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
S2276									
CMD		0		3.43	3.93	ur	3		0.081

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

52277

CPT Code: 52277 Global Period: 000 Source: HCFA Assigned (1992 only)
Current RVW: 6.17 CMD Recommended RVW: 3.44 AUA Survey RVW: 7.50
Medicare Frequency: 294 Proposed reduction: 44% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Cystourethroscopy, with resection of external sphincter (sphincterotomy)

Source and Summary of Comment to HCFA on this service: Carrier Medical Director comment. *Increment of work over 52000 is the same as for sphincterotomy or ablation over ERCP*

Reference code(s) used by CMD

52005 - Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service (RVW 2.37)

43260 - Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (RVW 5.96)

43262 - Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy (RVW 7.39)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 38-year old **male quadriplegic** with urinary retention and recurrent episodes of autonomic dysreflexia

Description of Pre-Service Work

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work

The patient is under spinal anesthesia. The urethra is dilated to 30 French. The 27 French resectoscope is introduced. The bladder, bladder neck and prostate are carefully inspected. The anterior prostatic capsule, urinary sphincter, and proximal 1 cm of bulbous urethra are resected down to fat. Bleeding is significant. A 22 French, 3-way 30 cc Foley is placed to bladder irrigation under traction.

Description of Post-Service Work

some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

If patient is stable and bleeding clears, he is dismissed home later that day.

SURVEY DATA:

52277

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 100% Median RVW: 7.50

25th Percentile RVW: 5.91 75th Percentile RVW: 9.00 Low: 3.50 High: 12.00

Median Pre-Service Time: 45 minutes Median Intra-Service Time: 45 minutes

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 60 minutes
Low: 15 minutes High: 100 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>0 minutes</u>	<u>0 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52235	Cystourethroscopy with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s) (2 to 5 cm)	5.45
2)	52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	11.51
3)	52000	Cystourethroscopy (separate procedure)	2.01

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - More time is required than for performing 52235

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 3 of 5
Technical skill and physical effort	Median response 3 of 5
Psychological stress	Median response 3 of 5

The Carrier Medical Directors comment that "the increment of work over 52000, cystoscopy, is the same as for sphincterotomy or ablation over ERCP." This rarely performed procedure (294 times performed in the Medicare population) is a technically demanding procedure, **performed in the operating room under spinal anesthesia**. The reference procedures are performed under sedation. The patients in the reference procedures are not quadriplegics and do not have all of the associated problems of the management of the quadriplegic patient.

The vignette describes the typical patient and likewise, the intra-service work description is typical. In these patients, the risk of autonomic dysreflexia is high. Also, these patients must be carefully monitored and sometimes the procedure must be abruptly terminated while the anesthesiologist regains control of hypertension.

The AUA survey of 7.50 is appropriate.

To suggest that this technically demanding, rarely performed procedure on quadraplegics be reduced to 3.44 RVWs is not based on rationale arguments.

Conclusion: The AUA recommends maintaining the current RVW of 6.17 or more appropriately, increase the RVWs for this procedure to 7.50.

CMD Comments

30-Jun-95

Code: 52277

1995 RVUs: 6.17

Recommended RVUs: 3.44

Ratio: -0.44

Long Descriptor: Cystourethroscopy, with resection of external sphincter (sphincterotomy)

Reference Set (y/n): N Global Period: 000 Frequency: 294 Impact: -802.62

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
52277			
	43260 ENDOSCOPY, BILE DUCT/PANCREAS	5.96	000
	43262 ENDOSCOPY, BILE DUCT/PANCREAS	7.39	000
	52005 CYSTOSCOPY & URETER CATHETER	2.37	000

CMD Comment:

Increment of work over 52000 is the same as for sphincterotomy or ablation over ERCP

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
52277	0	0	0	0	100	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
52277	215	210	-1.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
52277	80.9	70.5	-5.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
52277	urology	97.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
52277	344	15	OTHER PARALYTIC SYNDROMES
	586	5	RENAL FAILURE, UNSPECIFIED

CMD Comments

30-Jun-95

596	10	OTHER DISORDERS OF BLADDER
598	5	URETHRAL STRICTURE
599	5	OTHER DISORDERS OF URETHRA AND U
600	5	HYPERPLASIA OF PROSTATE
601	5	INFLAMMATORY DISEASES OF PROSTAT
788	5	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
52277							
CMD		000	000	6.19	6.17	1.00	6.17

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
52277								
CMD	6.17	6.17	1.00	1.00	1.00	1.00	3.44	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
52277								
CMD	000	6.19		30		42		33

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
52277									
CMD		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
52277									
CMD		0		3.44	6.17	ur	3		0.107

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

52500

CPT Code: 52500 Global Period: 090 Source: Harvard
Current RVW: 7.82 CMD Recommended RVW: 6.82 AUA Survey RVW: 7.82
Medicare Frequency: 8,594 Proposed reduction: 13% Harvard (Dunn) RUC Analysis:
Code not identified as overvalued

CPT Descriptor: Transurethral resection of bladder neck (separate procedure)

Source and Summary of Comment to HCFA on this service: *This is comparable to an 44950-appendectomy with a value of 6.13 or 63780 - insertion of an epidural pump buried with catheter with a value of 6.29. It is less than the value of 29881-knee arthroscopy with a value of 7.52.*

Reference code used by CMD:

44950 - Appendectomy (RVW 6.06)

63780 - Insertion or replacement, subarachnoid or epidural catheter, with reservoir and/or pump for drug infusion, without laminectomy (RVW 6.22)

29881- Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) (RVW 7.46)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old man has an AUA symptom index of 29/35. Prior medical treatment with both finasteride and alpha blockers was unsuccessful in improving urination. Peak urinary flow rate is 3 ml/sec, cystometrogram is normal. Cystoscopy reveals a small prostate with a tight, hypertrophied, bladder neck.

Description of Pre-Service Work

Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) Communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation and evaluation at which the decision to provide the procedure was made.

Description of Intra-Service Work

Connecting water, electosurgical unit, video equipment, urethra is dilated to 30F, 27F resectoscope is introduced, prostatic urethra bladder neck and bladder are inspected. The bladder neck is circumferentially resected. All bleeders are coagulated and bladder neck tissue fragments are removed from the bladder using the Ellik Evacuator. A catheter is placed.

Description of Post-Service Work

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for **90 days** after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

SURVEY DATA:

52500

Specialty: AMERICAN UROLOGICAL ASSOCIATION

Sample Size: 79 Response Rate (%): 100% Median RVW: 9.06

25th Percentile RVW: 8.00 75th Percentile RVW: 10.95 Low: 4.00 High: 12.00

Median Pre-Service Time: 40 minutes Median Intra-Service Time: 45 minutes

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 55 minutes

Low: 15 minutes High: 100 minutes

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 35 minutes

ICU: 0 minutes 0 visits

Other Hospital: 30 minutes 2 visits

Office: 45 minutes 3 visits

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	11.51
2)	52235	Cystourethroscopy with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s) (2 to 5 cm)	5.45

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

1) Time - key reference procedures are similar in time

2) Intensity - key reference procedures are similar in intensity

Mental effort and judgement	Median response 3 of 5
Technical skill and physical effort	Median response 3 of 5
Psychological stress	Median response 3 of 5

RATIONALE

52500

The Carrier Medical Directors' (CMD) comment that, "This is comparable to an 44950-appendectomy with a value of 6.13 or 29881-knee arthroscopy with a value of 7.52." An appendectomy is an open surgical procedure and it does not involve any form of body function after the procedure is completed. Transurethral resection of the bladder neck involves a working organ such as a knee. The patient must be able to urinate after the procedure. This is done for the correction of bladder neck obstruction. The technical skill required performing an endoscopic procedure is generally accepted by most specialties to be greater than to perform the same procedure by open methods (although we will not press that point). Comparing this to an open appendectomy is incorrect because these are totally different procedures.

It should be apparant that the post-operative follow-up in the office is much greater than that for an appendectomy.

The AUA survey suggest RVWs of 9.06.

The 25th percentile of 8.00 and 75th per of 10.95 are fairly tight.

Conclusion: We recommend that the RVW for this procedure be maintained at the current value of 7.82

CMD Comments

30-Jun-95

Code: 52500

1995 RVUs: 7.82

Recommended RVUs: 6.82

Ratio: -0.13

Long Descriptor: Transurethral resection of bladder neck (separate procedure)

Reference Set (y/n): N Global Period: 090 Frequency: 8,594 Impact: -8594

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
52500			
	29881 KNEE ARTHROSCOPY/SURGERY	7.46	090
	44950 APPENDECTOMY	6.06	090
	63780 INSERT SPINAL CANAL CATHETER	6.22	090

CMD Comment:

This is comparable to an appendectomy (44950) with a value of 6.13 or the insertion of an epidural pump buried with catheter (63780) with a value of 6.29. It is less than the value of 29881 (knee arthroscopy) with a value of 7.52.

Societies Wishing to Survey: AUA

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
52500	47.2	12	11.8	1.7	3	0.4	0	14.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
52500	10400	9534	-4.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
52500	63.7	54	-4.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
52500	urology	96.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
52500	185	2.3	MALIGNANT NEOPLASM OF PROSTATE
	188	2.9	MALIGNANT NEOPLASM OF BLADDER

CMD Comments

30-Jun-95

596	19.6	OTHER DISORDERS OF BLADDER
598	3.2	URETHRAL STRICTURE
599	3.1	OTHER DISORDERS OF URETHRA AND U
600	3	HYPERPLASIA OF PROSTATE
788	3.8	SYMPTOMS INVOLVING URINARY SYST

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
52500							
CMD		090	090	6.97	7.82	1.12	7.82

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
52500								
CMD	7.82	7.82	1.12	1.00	1.00	1.00	6.82	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
52500								
CMD	090	6.97		29		36		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
52500									
CMD		1.0		10	2.5		10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
52500									
CMD		15		6.82	7.82	ur	3		0.104

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Gynecology

The American College of Obstetricians and Gynecologists has had significant and long-standing concerns about the accuracy of the RBRVS for obstetric and gynecologic services. As elaborated in their public comments, ACOG feels that the work RVUs for services provided to women have been historically undervalued when compared to similar services on men or on similar anatomical structures. ACOG presented survey data and or arguments for 45 codes, 44 of which recommended increased RVUs. In addition to providing survey data, ACOG developed rationales based on a "building block" method using survey data on service characteristics and RVUs of established codes. The "building block" method also uses pre-, post-, and intra-service work intervals to assign physician values to the individual components of the global surgical services package. Appropriate E/M services for pre-service and post-service intervals were selected based on length of time, number of visits, clinical setting and judgement of level of care required. Using this method ACOG was able to arrive at work RVU estimates for surgical codes with a variety of global periods. On the basis of the survey, the building block and rational arguments ACOG successfully advocated numerous increases in work RVUs.

The survey data in almost every case supported an increase in RVU. The surveys had a minimum survey sample size of 100 and response rates in excess of 30%. The surveyed intra-service times were consistently and substantially greater than Harvard intra-service times. The RVU that was derived from a survey was in every case greater than the established RVU. When the building block method was used it produce results that confirmed survey data and argued for increased RVUs. Cross specialty comparisons were used by ACOG to validate both survey data and their building block method. Cross specialty comparisons were especially convincing when direct parallels could be drawn to similar services on men or similar procedures to manage like disease in different organs.

The RUC found the multiple independent points of validation convincing. The survey, building block and cross specialty comparisons typically supported the claim for increased RVUs. Generally the RUC was skeptical of the building block approach. It was felt that there was too much room for subjective selection of the E/M services. The RUC also recognized that the whole is not necessarily a sum of its parts. Typically the RUC would recommend the lowest RVU increase as suggested by one of the three methods.

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*Key (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3= Adopt specialty/CMD recommended decrease; 4= Adopt increased RVU, but lower than specialty recommended; 5= Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
56307	Laparoscopy; remove adnexa	5.60	10.68	Codes were grouped together because, although they are different procedures on a different patient population, they achieve the same end, the removal of adnexal structures. For all codes typically physician work exceeds 49000, <i>Exploratory laparotomy</i> . As a result, for all these codes the RVU should be greater than 49000, which is valued at 8.99. An exploratory laparotomy is the first step in removing any structures in the abdomen.	Survey data and building block rationale support increased RVUs. Cross specialty comparison to 56340, <i>laparoscopic cholecystectomy</i> , also suggested an increased RVU. Procedures should not be valued above 56340, <i>laparoscopic cholecystectomy</i> , which is a very similar procedure. The RUC recommends that 56307, 58720, 58925 and 59120 be given the same RVU as 56340.	4
58720	Removal of ovary/tube(s)	6.20	10.68			4
58925	Removal of ovarian cyst(s)	6.40	10.68			4
59120	Treat ectopic pregnancy	7.11	10.68			4
56309	Laparoscopy; remove myoma	5.60	13.79	The work required for both of these codes is approximately equal. The stress involved in 58140 may be slightly greater because it is open and these patients generally have larger myomas. Both entail more work than 49000, <i>Exploratory laparotomy</i> , and are valued lower.	Both codes can be compared to 56308, <i>LAVH</i> , which has an RVU of 13.87. Increases are supported by survey data showing median intra-service time of 165 and 110 min. and a median RVU of 14 and 12. Survey data and comparison to 56308, <i>LAVH</i> , are compelling evidence to increase the RVUs. The RUC recommends that the codes be linked to <i>LAVH</i> .	1
58140	Removal of uterus lesion	7.61	13.79			1

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
56605	Biopsy of vulva/perineum	0.86	1.10	Both codes are undervalued compared to 54100, <i>biopsy penis</i> , which is valued at 1.90. Codes 56605 and 56606 should be valued the same as 54100. Time, mental effort, technical skill and stress are nearly the same.	Compare to 54100, <i>biopsy penis</i> , which is valued at 1.90. Increases are supported by survey data for 56605 showing median intra-service time of 15 min. and a median RVU of 1.2. The RUC recommends that the codes be linked to 54100, <i>biopsy penis</i> , and 56605 and 56606 should be more in line with 54100.	1
56606	Biopsy of vulva/perineum	0.43	0.55			1
56633	Extensive vulva surgery	12.15	15.00	Code 56633 is undervalued in comparison to 19240, <i>mastectomy, modified, radical</i> , at 14.71 RVUs. Likelihood of infection and wound breakdown is greater for 56633.	Compare to 19240, <i>mastectomy, modified, radical</i> , at 14.71. Increases are supported by survey data which show a median intra-service time of 120 min. and a median RVU of 15. Building block method suggested 18.46 RVUs. Survey data and comparison to 19240 are compelling evidence to increase the RVU. The building block method is too high, but serves to validate the survey and the comparison. The RUC recommends that the RVU be increased.	4

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*Key (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
57110	Removal of vagina	13.48	13.48	Code 57110 requires more work than 58150, <i>total hysterectomy</i> . Physician times for this procedure are on average 40% greater than for 58150 and are more complex and require a greater intensity of work.	Survey data show a median intra-service time of 120 min. which is greater than Harvard data. However, the difference from the 95 RVU and the building block value of 13.93 is not significant. The RUC recommends that the current value be maintained.	2
57150	Treat vagina infection	0.94	0.55	This code seems to be overvalued compared to 99214, <i>office visit established patient</i> .	Survey data show median intra-service time of 10 min. and a median RVU of 0.55. Building block method was not used. The survey data does not measure up to current values. The RUC recommends that the RVU be reduced.	3
57265	Extensive repair of vagina	7.36	7.36	This code is undervalued in comparison to 57260, <i>Repair of vagina</i> , which is valued at 7.59 RVUs.	The specialty society has withdrawn its comment. The RUC recommends that the current RVU be maintained	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
57270	Repair of bowel pouch	7.36	11.30	Code requires more work than 49000, <i>Exploratory laparotomy</i> , yet is assigned fewer RVUs. Primary difference in work occurs in the intra-service period where 57270 requires greater mental effort, skill and stress.	In each of these cases survey data are significantly greater than current values for intra-service time and RVUs. 57270 had a median intra-service time of 90 min and a median RVU of 11.3. 57280 had a median intra-service time of 115 min and a median RVU of 14.1. The RUC recommends that the RVUs be increased.	4
57280	Suspension of vagina	8.35	14.10			4
57289	Repair bladder & vagina	6.40	10.80	Code is undervalued compared to 51845, <i>Repair bladder neck</i> , which has 9.06 RVUs. Both procedures are performed to correct urinary incontinence. 57305 entails all the procedures in 51845, but also involves a anterior colporrhaphy.	57289 had a median intra-service time of 90 min and a median RVU of 10.80. The value suggested by the building block method are greater than median survey RVU. Survey data shows compelling evidence to increase the RVU. The building block are too high, but serves to validate the survey. The RUC recommends that the RVU be increased.	4

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*Key (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3= Adopt specialty/CMD recommended decrease; 4= Adopt increased RVU, but lower than specialty recommended; 5= Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
57305	Repair rectum-vagina fistula	8.69	12.75	The RVUs are undervalued for 57305 and 57307. These codes greatly exceed the technical skill, mental effort and judgement required for 49000, <i>Exploratory laparotomy</i> . Harvard RVUs per minute are below the level of 49000, even though 57305 and 57307 are more difficult. Both codes make use of 49000, but also entail several additional procedures, 57307 requires a colostomy.	Survey data show median intra-service times of 120 min. and a median RVU of 15.75 for 57305. Building block suggested 14.75 for 57305. Both procedures are compared to similar procedures done in men; 45800, <i>closure recto vesical fistula</i> , and 45805, <i>repair recto vesical fistula with colostomy</i> . Survey data, building block and comparisons provide compelling evidence to increase the RVUs. The RUC recommends that the procedures be linked to similar procedures in men. 57305 is linked to 45800 and 57307 is linked to 45805.	4
57307	Fistula repair & colostomy	10.05	15.08			4

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*Key (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3= Adopt specialty/CMD recommended decrease; 4= Adopt increased RVU, but lower than specialty recommended; 5= Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
57400	Dilation of vagina	0.83	2.27	Both codes are undervalued compared to 99221, <i>level 1 initial hospital visit</i> . These procedures entail the risk of general anesthesia which makes them more stressful than 99221.	These codes specify the use of anesthesia. Both procedures do not usually require anesthesia, suggesting that 57400 and 57410 are performed on a special group of patients. Pre and post-service care is comparable to 99222, <i>initial hospital care</i> . Survey data show median intra-service times of 20 and 15 min. and a median RVU of 2.95 and 2.72. Building block suggests 2.27 for 57400. The RUC recommends that the RVUs suggested by the specialty society. Survey, building block and comparisons provide compelling evidence for increase.	1
57410	Pelvic examination	0.59	1.75			1
57415	Removal vaginal foreign body	0.91	2.12	This code is undervalued in comparison to 42809, <i>removal of foreign body from pharynx</i> , which is valued at 1.76. 57415 is performed under general anesthesia not local as in 42809. Also, the impacted nature of procedure makes 57415 more demanding in terms of physical effort and technical skill.	Building block suggests 2.12 RVUs. Building block RVU is accepted. It is lower than the survey RVU which it rests on for validation. The comparison to 42809, <i>removal of foreign body from pharynx</i> , provides further compelling evidence. The RUC recommends that the RVU be increased.	1

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
57540	Removal of residual cervix	6.01	11.54	These codes are undervalued. Evidence of the low RVUs is Harvard data which shows RVUs per minute for 49000, <i>Exploratory laparotomy</i> , that are greater than 57540 and 57545. Both codes require more technical skill, mental effort and stress than 49000 which has more RVUs. 57545 also requires the extra time and work of a pelvic floor repair.	Survey data show median intra-service time of 75 and 120 min. and a median RVU of 11.54 and 12.3. Building block suggests 11.94 RVUs for 57540. Survey data is accepted for the increased RVU. Building block helps to validate survey. The RUC recommends that the RVU be increased.	4
57545	Remove cervix, repair pelvis	6.63	12.30			4
58120	Dilation and curettage (D&C)	2.45	2.91	Newer procedures such as 58100, <i>Biopsy of uterus lining</i> , and 56350, <i>diagnostic hysteroscopy</i> , have replaced 58120. When 58120 is done the patient is usually sicker because other procedures were not possible due to complications. As a result the work for 58120 has increased.	Survey data show median intra-service time of 25 min. and a median RVU of 3.73. Building block suggests 3.56 RVUs. Survey data and building block are used as a guides. The RUC recommends same value as 59840, <i>abortion</i> .	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
58150	Total hysterectomy	13.00	14.30	Procedures are not done very frequently. The development of <i>LAVH</i> allows many woman to have a vaginal hysterectomy. Patients requiring these procedure are usually sicker because other alternatives were not possible due to complications. Both entail significantly greater work than 49000, <i>Exploratory laparotomy</i> , which is the first part of these procedures.	Survey data show median intra-service times of 120 and 130 min. and median RVUs of 14.3 and 15. Building block suggests 16.33 and 16.57 RVUs. Compare to 58260, <i>vaginal hysterectomy</i> , and 56308, <i>LAVH</i> . Building blocks are too high, but serves to validate survey. The survey data indicate that an increase is in order. However, evidence of increased difficulty for 57180 is not compelling and it is given the same value as 57150. The RUC recommends that the RVUs be increased.	4
58180	Partial hysterectomy	9.06	14.30			4
58200	Extensive hysterectomy	20.34	20.34	Procedure involves greater total work than does 58150, <i>Total hysterectomy</i> . Level of complexity and intensity is also higher for 58210.	Survey data show median intra-service time of 150 min. and a median RVU of 17.5. Building block suggests 20.95 RVUs. Recommended increase is not substantial The survey RVU came out lower than current RVU. The RUC recommends that the current value be maintained.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
58210	Extensive hysterectomy	23.97	27.50	Total work for code 58210 is equivalent to 55845, <i>extensive prostate surgery</i> , valued at 26.73. Both codes should be valued the same.	Survey data show median intra-service time of 240 min. and a median RVU of 27.50. Building block suggests 28.23 RVUs. Argue that 58210 is more difficult than 55845, <i>extensive prostate surgery</i> (26.73). Survey data along with building block and comparison offers compelling evidence to increase the RVU. The RUC recommends that the RVU be increased.	4
58240	Removal of pelvis contents	28.79	35.27	Code 58240 is undervalued in comparison to 51597, <i>removal of pelvic structures</i> , which is valued at 35.27. These procedures are virtually identical except that one is done in women and the other is done in men.	Survey data show median intra-service time of 480 min. and a median RVU of 35. Building block suggests 41.20 RVUs. Argue that 58240 is the same as the male procedure, 51597 (<i>removal of pelvic structures</i>), which is valued at 35.27. The RUC recommends that this procedure have an equal number of RVUs to the same procedure on a male. Survey data and building block add further compelling evidence.	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
58301	Remove intrauterine device	0.73	1.27	This code is undervalued in comparison to 42809, <i>removal of foreign body from pharynx</i> , which is valued at 1.76. Although 58301 does not entail as much work as 42809, its RVU should be somewhere between 0.73 and 1.76.	Survey data show median intra-service time of 15 min. and a median RVU of 1.5. Society compared the code to 99215, <i>level 5 office visit</i> . The RUC believes that the procedure is more appropriately compared to a <i>level 4 office visit</i> , 99214. The RUC recommends a links to 99214. The recommendation for 58301 will be the same as the recommendation for 99214, 1.27 RVUs.	4
58323	Sperm washing	0.23	0.23	Should have an RVU closer to 99201, <i>Level 1 new patient office visit</i> , which has an RVU of 0.38.	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment. The RUC previously recommended a 0.30 in 1993 and the code was through a HCFA refinement panel in 1994.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
58410	Suspension of uterus	6.78	12.00	Requires total physician effort at least equivalent to 49000, <i>Exploratory laparotomy</i> , but is assigned fewer RVUs. Harvard data indicate an intra-service time of 91 min and an intra-service intensity of 0.030 RVUs per minute. This represents more time and lower intensity than 49000, showing the code to be undervalued.	Survey data show median intra-service time of 110 min. and a median RVU of 12. Building block suggests 12.31 RVUs. Accepts survey data. Building block serves to validate survey. Similar code, 58400 (<i>suspension of uterus</i>), was not in five year review. The RUC recommends that the RVU be increased.	4
58520	Repair of ruptured uterus	6.35	11.11	Both codes involve the repair of the uterus. 58520 is the case of a ruptured uterus and is done in an emergency situation. 58540 is the repair of a deformed uterus. Both codes are undervalued when compared to 49000, <i>Exploratory laparotomy</i> , which is part of the procedure for each.	Survey data show median intra-service time of 90 and 120 min. and a median RVU of 12 and 14. Building block suggests 11.11 and 13.96 RVUs. 58520 is comparable in time, mental effort, technical skill and stress to 51860, <i>repair of bladder wound</i> . 58540 requires less work but more time than 59515, <i>cesarean delivery</i> . Building block is less RVUs than surveys or comparisons. Accept building block with survey and comparisons as validation. The RUC recommends that the specialty society suggested RVU be accepted.	1
58540	Revision of uterus	8.58	13.96			1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
58750	Repair oviduct(s)	8.82	14.26	Both codes are undervalued. They require more time, mental effort, technical skill and stress than 49000, <i>Exploratory laparotomy</i> . 49000 is the first part of both procedures and as a result the two codes should be valued higher than 49000.	Survey data show median intra-service time of 120 and 150 min. and a median RVU of 14.26 and 14.5. Building block suggests 15.14 RVUs for both codes. Compare these codes to the combination of 49000, <i>exploratory laparotomy</i> , and 55400, <i>vaso vasostomy</i> . The RUC recommends that the RVU be increased to the level of the survey data. The building block serves to validate survey. Survey data are similar for 58750 and 58752. Both codes are given the same RVU.	4
58752	Revise ovarian tube(s)	7.94	14.26			4
58760	Remove tubal obstruction	7.16	12.50	This code require more time, mental effort, technical skill and stress than 49000, <i>Exploratory laparotomy</i> , but it is valued with fewer RVUs. Harvard data indicate an intra-service time of 88 min and an intra-service intensity of 0.036 RVUs per minute. This represents more time and lower intensity than 49000, showing the code to be undervalued.	Survey data show median intra-service time of 120 min. and a median RVU of 12.50. Building block suggests 12.86 RVUs. compare to 44055, <i>freeing of bowel adhesions</i> (11.92). The RUC recommends the survey data for the new RVU. The building block and comparison serve to validate survey.	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
58770	Create new tubal opening	6.96	13.34	Code 58770 require more time, mental effort, technical skill and stress than 49000, <i>Exploratory laparotomy</i> , but it is valued with fewer RVUs. Harvard data indicate an intra-service time of 78 min and an intra-service intensity of 0.039 RVUs per minute. This represents more time and lower intensity than 49000, showing the code to be undervalued.	Survey data show median intra-service time of 120 min. and a median RVU of 13.45. Building block suggests 13.34 RVUs. Building block is less than survey. The RUC recommends the building block for new RVU. The survey data validates the building block.	1
58822	Drainage of ovarian abscess	6.18	9.06	Total work for 58822 is as least as great as 49000, <i>Exploratory laparotomy</i> , but it has fewer RVUs. According to Harvard data the intra-service time for 58822 and 49000 are approximately the same, but 58822 has a lower intensity. This shows that 58822 is undervalued.	Comparison is made to cross specialty reference 49020, <i>drainage abdominal abscess</i> (9.06). Survey RVU was 12 and median intra-service time was 90 min. The RUCs recommendation is for the same RVU as 49020. Believes that comparison is legitimate, very similar procedures.	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
58952	Resect ovarian malignancy	21.35	23.35	Total work for 58952 is greater than 49215, <i>Excise sacral spine tumor</i> , valued at 21.05. Intra-service work for 58952 requires more time, mental effort, and technical skill.	Survey data show median intra-service time of 240 min. and a median RVU of 23.35. Building block suggests 23.08 RVUs. Survey and building block estimates are very close. The RUC recommends the survey data for the new RVU. Use the building block as validation.	4
58960	Exploration of abdomen	10.14	13.66	The total work is similar to 49220, <i>multiple surgery abdomen</i> , at 13.66, but is valued less. Code 58960 includes 49000, <i>Exploratory laparotomy</i> , at 8.99 and 38562, <i>Removal pelvic lymph nodes</i> , at 9.65. 58960 is clearly undervalued.	Survey data show median intra-service time of 150 min. and a median RVU of 16. Building block suggests 16.55 RVUs. Compares to 49220, <i>multiple surgery abdomen</i> (13.66). The RUC suggests that 58960 is about as difficult as 49220 and therefore should not have a larger RVU. The RUC recommends the same RVU as 49220.	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
59100	Remove uterus lesion	5.96	11.54	Total work for 59100 is greater than 49000, <i>Exploratory laparotomy</i> , but is valued less. Harvard data indicate an intra-service time of 69 min and an intra-service intensity of 0.041 RVUs per minute. This represents as much time and lower intensity than 49000, showing the code to be undervalued.	Survey data show median intra-service time of 60 min. and a median RVU of 14. Building block suggests 11.54 RVUs. Compares to 58520, <i>repair of ruptured uterus</i> . 59100 is seen as more work in that it also requires removal. The RUC recommends the lower value of survey and building block.	4
59121	Treat ectopic pregnancy	6.99	10.99	Total work for 59121 exceeds the work for 49000, <i>Exploratory laparotomy</i> , but is valued lower. 59121 should have at least equivalent RVUs to 49000.	This is an open procedure that is performed on patients who do not respond to other treatments. Often performed in an emergency situation. Survey RVU of 12.00 and median intra-service time of 90 min. Building block suggests 10.99 RVUs. Building block is less than survey. The RUC recommends the building block as the new RVU with survey as validation.	1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
59130	Treat ectopic pregnancy	7.88	13.49	Code 59130 and 59136 are undervalued when compared to 49000. These code requires an exploratory laparotomy. Harvard data indicate an intra-service time of 62 min and 76 min an intra-service intensities of 0.066 and 0.065 RVUs per minute. This represents as much time and lower intensity than 49000, showing the code to be undervalued. The RVUs for 59130 59136 does not account for the increased difficulty associated with treating an abdominal pregnancy.	Survey data show median intra-service time of 120 and 90 min. and a median RVU of 13.49 and 12.5. Building block suggests 14.94 and 13.06 RVUs. The RUC recommends the survey data for the new RVU. Building block is close and serves as validation.	4
59136	Treat ectopic pregnancy	8.69	12.50			1
59841	Abortion	3.24	4.80	The profile of patients for 59841 has changed making this procedure undervalued compared to 59840, <i>Induced abortion by D&C</i> . A higher proportion of pregnancies terminated by this method, 59841, are now greater than 16 weeks. This has caused physician work to increase.	Survey data show median intra-service time of 35 min. and a median RVU of 4.8. Building block suggests 5.7 RVUs. The RUC recommends the survey data as the new RVU. Building block was close and serves as validation.	4

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**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 56307 Global Period: 010 Current RVW: 5.6 Recommended RVW: 11.55

CPT Descriptor: Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy).

Source and Summary of Comment to HCFA on this service: ACOG: Undervalued in comparison to CPT 58720, the open equivalent of 56307. Both should have the same value (note 58720 believed to be undervalued).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52 year old post menopausal woman has been evaluated for an adnexal mass palpated on routine exam. She had a vaginal hysterectomy 15 years ago for benign disease. Ultrasound documents a 5 cm simple cystic mass arising from the left adnexa. Color doppler flow analysis shows a normal resistive index and CA-125 is 5. Diagnostic laparoscopy confirms a benign appearing cystically enlarged left ovary. Additional operating ports are placed and the left tube and ovary are excised laparoscopically and placed in a bag. If possible they are removed from the abdominal cavity in the bag. Frozen section confirms a benign cystadenoma. The right tube and ovary are free of apparent abnormality and are left in place. The patient is observed in the hospital for 8-24 hours and discharged home with instructions. The patient receives routine office follow-up care during the 10 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

A bimanual pelvic examination is done to assess uterine size, position, and mobility before insertion of an uterine cannula. Exposure of the cervix is obtained. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. Pneumoperitoneum is achieved by insertion of a Veress or Touhy needle at the inferior rim of the umbilicus through a 2 mm incision. The peritoneal space is insufflated with carbon dioxide gas to a pressure of 10 mm HG. Once satisfactory displacement of organs is achieved, the 2 mm incision is extended to 1 cm and the laparoscope trocar and sleeve are inserted through the rectus fascia. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis. The gas hose is then connected to the trocar.

Once the laparoscope has been inserted a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis is viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration additional trocars are placed under direct vision as needed. The infundibulopelvic ligament is isolated and the ureter is protected while the ovarian pedicle is controlled using staples, suture, electrocoagulation or clips. The adnexal structures are separated from the round ligament and any other adhesions or attachments are divided. The structures are now free and must be removed from the abdomen either via a colpotomy incision or by extending one of the abdominal incisions. If the ovary contains a cyst, it may be placed in a sterile bag, allowing the cyst to be aspirated and deflated without spilling its contents intra-abdominally. The pelvis is then carefully observed under water or low CO₂ pressure to assure hemostasis. Ancillary trocars are

then removed under direct vision and the insertion sites are observed for bleeding. The abdomen is deflated. The fascia may be closed separately, then the skin wounds are closed. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 1 day. The patient is discharged on post op day 1 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:

Specialty: ACOG

Sample Size: 100 Response Rate (%): 32 (32%) Median RVW: 10.5

25th Percentile RVW: 9.75 75th Percentile RVW: 12.35 Low: 5.75 High: 15

Median Pre-Service Time: 55 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 110 Low: 50 High: 120

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>20</u>	<u>1</u>
Office:	<u>25</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	56340	Cholecystectomy	10.68
2)	56360	Peritoneoscopy without biopsy	4.04
3)	49000	Exploratory laparotomy	8.99
4)	56308	LAVH	13.87

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The physician time, mental effort, skill, and risk associated with CPT 56307 are similar to the work required to perform CPT 56340. CPT 56307 requires slightly less physician work than CPT 56308.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215 x 2 - 1.51
Intra-service	90 min. x 0.060/5.4
Same day	99215 1.51
Hosp.	99238 1.06
Office	99213 <u>.55</u>
	Total 10.03

Note: The recommended RVU is the average of the survey medians for CPT56307 and 58720, the open procedure. The same value is recommended for both procedures.

Public Comments

30-Jun-95

Code: 56307

1995 RVUs: 5.6

Recommended RVUs: 6.20

Ratio:

Long Descriptor: Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)

Reference Set (y/n): N Global Period: 010 Frequency: 2,241 Impact: 1345

Source: 4 Year: 93 Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment: AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
56307	19	1.6	11.1	100	14.3	0	0	12.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
56307	.	2237	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
56307	.	52.6	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
56307	general surgery	12.2
	obstetrics/gynecology	83.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
56307	220	2	BENIGN NEOPLASM OF OVARY
	568	1.6	OTHER DISORDERS OF PERITONEUM
	614	6.7	INFLAMMATORY DISEASE OF OVARY, F
	618	2	GENITAL PROLAPSE

Public Comments

30-Jun-95

620	12.3	NONINFLAMMATORY DISORDERS OF OV
625	6	PAIN AND OTHER SYMPTOMS ASSOCIAT
627	2.8	MENOPAUSAL AND POSTMENOPAUSAL
789	3.6	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
56307							
ACOG			010		5.60		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
56307								
ACOG	5.60	5.60			1.00	1.00	6.20	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
56307								
ACOG	010							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
56307									
ACOG									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
56307									
ACOG				6.20	5.60				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58720 Global Period: 090 Current RVW: 6.2 Recommended RVW: 11.55

CPT Descriptor: Salpingo-oophorectomy, complete or partial, unilateral or bilateral

Source and Summary of Comment to HCFA on this service: ACOG: Requires physician work at least equivalent to that associated with CPT 49000, but has fewer work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54 year old female patient has been evaluated for pelvic pain and was found to have bilateral ovarian cysts. She underwent a vaginal hysterectomy 15 years prior to this time for cervical dysplasia. The patient fails conservative methods of treatment and is taken to surgery where a bilateral salpingo-oophorectomy is performed because of bilateral dermoid cysts. The ovaries are densely adherent to the vaginal vault. Bowel adhesions to both the ovaries and the abdominal wall are present from her prior hysterectomy. The patient has an uneventful post-operative recovery and is discharged from the hospital on the third post-op day. She is seen in the office for a 6 weeks post-op evaluation and is released to her usual activities.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

Under general anesthesia the abdomen is entered through a lower midline or transverse incision. The bowel contents are packed away and the ovaries and tubes are exposed and isolated. Often-times there will be adhesions that must be lysed in order to expose the appropriate anatomy. The vascular supply of the tubes and ovaries is ligated and divided and the organs are removed. Hemostasis is achieved and the abdomen is closed.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 200 Response Rate (%): 37 (19%) Median RVW: 1325th Percentile RVW: 10.94 75th Percentile RVW: 14 Low: 9 High: 20Median Pre-Service Time: 52 Median Intra-Service Time: 12025th Percentile Intra-Svc Time: 86 75th Percentile Intra-Svc Time: 120 Low: 55 High: 180

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>---</u>	<u>---</u>
Other Hospital:	<u>45</u>	<u>3</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	56308	LAVH	13.87
3)	58260	Vaginal hysterectomy	11.39
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Pre-service work is greater for CPT 58720 than for CPT 49000: in addition to the usual pre-operative history, physical, and medical record review, the physician performing CPT 58720 must counsel the patient about the removal of the tubes and ovaries, the resulting loss of fertility, and accompanying hormonal changes. During the intra-service period, CPT 58720 includes the work of CPT 49000, in addition to the work required to remove the tubes and ovaries.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	105 min. x .06	-	6.3
Day of service	99214	-	.94
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99213	-	.55
	99212	-	<u>.38</u>
			12.13

Note: The recommended RVUs equal the recommendation for CPT 56307, the equivalent laparoscopic procedure. The recommended RVU is the average of the survey medians for CPT 58720 and 56307. Patients undergoing 58720 may be more difficult because of the presence of conditions that preclude use of the laparoscopic procedure.

Public Comments

30-Jun-95

Code: 58720

1995 RVUs: 6.2

Recommended RVUs: Inc

Ratio:

Long Descriptor: Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

Reference Set (y/n): N Global Period: 090 Frequency: 7,647 Impact:

Source: 1 Year: 92 Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58720	41.9	6.4	9	100	12.7	0	1	16.5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58720	8996	8460	-3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58720	94.4	95.8	0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58720	general surgery	32.1
	group practices	2.1
	obstetrics/gynecology	60.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58720	153	2.1	MALIGNANT NEOPLASM OF COLON
	183	1.6	MALIGNANT NEOPLASM OF OVARY AND
	220	3.6	BENIGN NEOPLASM OF OVARY
	614	3.4	INFLAMMATORY DISEASE OF OVARY, F

Public Comments

30-Jun-95

618	3.3	GENITAL PROLAPSE
620	7.8	NONINFLAMMATORY DISORDERS OF OV
625	3.1	PAIN AND OTHER SYMPTOMS ASSOCIAT
789	4.8	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58720							
ACOG		090	090	6.24	6.20	0.99	6.20

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58720								
ACOG	6.20	6.20	0.99	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
58720								
ACOG	090	6.24		22		52		41

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58720									
ACOG		1.0		10	3.0		10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
58720									
ACOG		15		INCR	6.20	ob	3		0.055

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58925 Global Period: 090 Current RVW: 6.4 Recommended RVW: 11.71

CPT Descriptor: Ovarian Cystectomy

Source and Summary of Comment to HCFA on this service: ACOG: Requires equivalent, if not greater physician work than CPT 49000, but has fewer work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old G0P0 woman with a persistent 6 cm complex adnexal mass is admitted for definitive therapy. You perform an ovarian cystectomy, including exploratory laparotomy, analysis of minor adhesions, removal of the ovarian cyst(s), and reconstruction of the ovary. Frozen section is done to confirm that the cyst is benign prior to completing closure of the abdomen. After hospital discharge, the patient receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Intra-Service Work:

Exploratory laparotomy. Lysis of minor adhesions. Removal of the ovarian cyst(s). Reconstruction of the ovary. Obtaining hemostasis. Closure of the abdomen.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:

Specialty: ACOG

Sample Size: 100 Response Rate (%): 31 (31%) Median RVW: 11.28

25th Percentile RVW: 9.6 75th Percentile RVW: 12 Low: 9 High: 16

Median Pre-Service Time: 60 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 104 Low: 45 High: 180

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>35</u>	
ICU:	<u>---</u>	<u>---</u>
Other Hospital:	<u>45</u>	<u>3</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	56308	LAVH	13.87
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58925 is greater in total physician work than CPT 49000. In addition to exploring the abdomen, the physician removes a cyst or cysts from one or both ovaries and closes the incision(s) on the ovary(s). Typically, the only patients who undergo an ovarian cystectomy through laparotomy, rather than laparoscopy are those who have very large cysts and/or who are obese. Therefore the technical skill required to safely perform CPT 58925 on the typical patient is greater than required for CPT 49000. In addition, stress is somewhat higher due to risk of future infertility secondary to adhesions formed as a result of the surgery.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	90 min. x .06	-	5.4
Day of service	99233	-	1.25
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99213 x 2	-	<u>1.1</u>
			11.71

Public Comments

30-Jun-95

Code: 58925

1995 RVUs: 6.4

Recommended RVUs: Inc

Ratio:

Long Descriptor: Ovarian cystectomy, unilateral or bilateral

Reference Set (y/n): N

Global Period: 090

Frequency: 1,000

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58925	43.3	3.3	16.7	100	26.7	0	3.3	17.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58925	1174	1040	-5.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58925	89	88.8	-0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58925	general surgery	47.8
	general/family practice	2.7
	group practices	2.7
	obstetrics/gynecology	42.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58925	151	1.7	MALIGNANT NEOPLASM OF STOMACH
	153	2.5	MALIGNANT NEOPLASM OF COLON
	220	1.7	BENIGN NEOPLASM OF OVARY

Public Comments

30-Jun-95

236	3.3	NEOPLASM OF UNCERTAIN BEHAVIOR O
555	1.7	REGIONAL ENTERITIS
620	11.7	NONINFLAMMATORY DISORDERS OF OV
625	3.3	PAIN AND OTHER SYMPTOMS ASSOCIAT
789	4.2	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58925							
ACOG		090	090	6.45	6.40	0.99	6.40

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58925								
ACOG	6.40	6.40	0.99	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
58925								
ACOG	090	6.45		29		53		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58925									
ACOG		1.0	*	10	3.5		15	0.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58925									
ACOG		15		INCR	6.40	ob	n		0.046

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 59120 Global Period: 090 Current RVW: 7.11 Recommended RVW: 11.78

CPT Descriptor: Surgical treatment of ectopic pregnancy, tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach

Source and Summary of Comment to HCFA on this service: ACOG: Entails greater mental effort, technical skill, and stress than CPT 49000, but has fewer work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34 year old primigravida presents with signs and symptoms of hypovolemia, a greatly distended abdomen, and signs of hemoperitoneum. She is taken to surgery with fluid replacement and undergoes an exploratory laparotomy with evacuation of the hemoperitoneum. Findings are a ruptured left isthmic tubal pregnancy with a hematosalpinx throughout the remnant of her left fallopian tube. She has a normal contralateral adnexa. A unilateral salpingectomy is performed. After hospital discharge, the patient receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

An incision is made in the lower abdomen, and the pelvic cavity is explored. An inspection of the gestation site is performed for bleeding. All of the products of conception, clots, and free blood are removed. A unilateral salpingectomy is performed due to findings of a ruptured left isthmic tubal pregnancy with hematosalpinx. This is accomplished by cutting a small wedge of the uterine wall at the junction of the fallopian tube and body of the uterus. The pelvis is lavaged with saline solution and the abdomen closed.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 4 days. The patient is discharged on post op day 4 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 150 Response Rate (%): 45 (35%) Median RVW: 1125th Percentile RVW: 10.85 75th Percentile RVW: 14 Low: 9 High: 18Median Pre-Service Time: 60 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 45 High: 120

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>45</u>	<u>4</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	58700	Salpingectomy	5.92
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Total physician work for CPT 59120 is approximately equivalent to CPT 49000, plus CPT 58700. Applying the multiple procedure payment rule would yield 11.95 RVUs, so the survey median and building block approach seemed to yield reasonable results.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	75 min. x .075	-	5.62
Day of service	99233	-	1.25
Hospital	99231 x 2	-	1.02
	99238	-	1.06
Office	99214	-	.94
	99212	-	<u>.38</u>
			11.78

Note: We are recommending 11.55 RVUs for CPT 58720 and 56307. Work for CPT 59120 is similar, although the patient is sicker.

Public Comments

30-Jun-95

Code: 59120

1995 RVUs: 7.11

Recommended RVUs: Inc

Ratio:

Long Descriptor: Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach

Reference Set (y/n): N Global Period: 090 Frequency: 73 Impact:

Source: 1 Year: 92 Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
59120	0	0	33.3	100	100	0	0	0

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
59120	72	82	6.7

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
59120	84.7	78	-3.3

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
59120	general surgery	4.9
	group practices	7.3
	internal medicine	2.4
	obstetrics/gynecology	85.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
59120	633	25	ECTOPIC PREGNANCY

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
59120							
ACOG		090	090	7.33	7.11	0.97	7.11

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
59120								
ACOG	7.11	7.11	0.97	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
59120								
ACOG	090	7.33		30		55		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
59120									
ACOG		1.0	*	10	3.5		15	0.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
59120									
ACOG		15		INCR	7.11	ob	3		0.058

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 56309 Global Period: 010 Current RVW: 5.6 Recommended RVW: 13.79

CPT Descriptor: Laparoscopy, surgical; with removal of leiomyomata, subserosal (single or multiple)

Source and Summary of Comment to HCFA on this service: ACOG: Undervalued in comparison to CPT 58140, the open equivalent of 56309. Both should have the same value (note 58140 believed to be undervalued).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42 year old multigravida woman has been evaluated for an enlarging symptomatic pelvic mass. The uterus has increased from 6 to 12 weeks' size over 8 months and is causing urinary frequency, nocturia, and dyspareunia. Ultrasound documented a leiomyomatous uterus with two separate myomas 4x5 and 3x4 cm. The patient does not want a hysterectomy. She now undergoes laparoscopy which reveals fibroids in subserosal and intramural locations. At the same operative setting, additional operating ports are placed and the myomas excised. Morcellation is accomplished to permit removal of the dense tumors from the abdomen. Intracorporeal suturing is done closing the uterus in layers, and hemostasis is achieved. The patient is observed in the hospital for 8-24 hours and is discharged home. The patient receives routine office follow-up care during the 10 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

A bimanual pelvic examination is done to assess uterine size, position, and mobility before insertion of an uterine cannula. Exposure of the cervix is obtained. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. Pneumoperitoneum is achieved by insertion of a Veress or Touhy needle at the inferior rim of the umbilicus through a 2 mm incision. The peritoneal space is insufflated with carbon dioxide gas to a pressure of 10 mm HG. Once satisfactory displacement of organs is achieved, the 2 mm incision is extended to 1 cm and the laparoscope trocar and sleeve are inserted through the rectus fascia. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis. The gas hose is then connected to the trocar.

Once the laparoscope has been inserted a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis is viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration, uterine incisions are planned and ancillary trocars and instruments are placed as needed. Dilute Pitressin (vasopressin) solution may be injected into the uterine serosa to improve hemostasis. Incisions are made into the uterus overlying the leiomyomata and the tumors are dissected from the myometrium. The uterus is then closed in layers using intracorporeal suturing to achieve hemostasis and adequate reapproximation of the tissues. The fibroids are then morcellated either intra-abdominally or at the abdominal wall to permit extraction from the abdominal cavity. The uterus is observed and hemostasis assured.

Ancillary trocars are then removed under direct vision and the sites are observed for bleeding. The abdomen is deflated. The fascia may be closed separately, then the skin wounds are closed. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 1 day. The patient is discharged on post op day 1 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:

Specialty: ACOG

Sample Size: 100 Response Rate (%): 27 (27%) Median RVW: 14

25th Percentile RVW: 13.6 75th Percentile RVW: 15 Low: 10.1 High: 18

Median Pre-Service Time: 60 Median Intra-Service Time: 165

25th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 180 Low: 75 High: 240

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>---</u>	<u>---</u>
Other Hospital:	<u>30</u>	<u>1</u>
Office:	<u>28</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	56308	LAVH	13.87
2)	49000	Exploratory laparotomy	8.59
3)	58140	Myomectomy abdominal approach	7.61
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 56309 requires significantly greater mental effort and technical skill than CPT 49000 due to the removal of myomas and subsequent suturing of the uterus. In addition, stress is higher due to the risk of excessive bleeding. The work of CPT 56309 fairly closely approximates the work of CPT 56308.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	-	99215	1.51
Intra-service	-	165 min. x 0.06	9.9
Same day	-	99232	.88
Hosp.	-	99238	1.06
Office	-	99213	<u>.55</u>
			13.9

Note: The recommended RVUs equal the recommendation for CPT58140, the equivalent open procedure. The recommended RVUs are the average of the results of the building block approach for 56309 and 58140.

Public Comments

30-Jun-95

Code: 56309

1995 RVUs: 5.6

Recommended RVUs: 7.61

Ratio:

Long Descriptor: Laparoscopy, surgical; with removal of leiomyomata, subserosal (single or multiple)

Reference Set (y/n): N Global Period: 010 Frequency: 71 Impact: 143

Source: 8 Year: 93 Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment: AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
56309	0	0	0	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
56309		91	

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
56309		29.7	

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
56309	general surgery	7.7
	group practices	4.4
	obstetrics/gynecology	87.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
56309	218	25	UTERINE LEIOMYOMA
	625	25	PAIN AND OTHER SYMPTOMS ASSOCIAT
	627	25	MENOPAUSAL AND POSTMENOPAUSAL

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
56309							
ACOG			010	.	5.60	.	.

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
56309								
ACOG	5.60	5.60	.	.	1.00	1.00	7.61	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
56309								
ACOG	010	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
56309									
ACOG

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
56309									
ACOG	.	.	.	7.61	5.60	.	.	.	.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58140 Global Period: 090 Current RVW: 7.61 Recommended RVW: 13.79

CPT Descriptor: Myomectomy, excision of fibroid tumor of uterus, single or multiple (separate procedure); abdominal approach

Source and Summary of Comment to HCFA on this service: ACOG: Requires approximately equivalent time and significantly more mental effort, technical skill, and stress than CPT 49000, but work RVUs are lower. More closely approximates the work of CPT 58150

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 37 year old G1P0 woman was referred for abnormal uterine bleeding causing anemia. The patient has been treated pharmacologically and has received a dilatation and curettage during the past year without success. The patient has also experienced heavier and longer menses and dysmenorrhea over the past 6 months. Multiple scattered intramural and subserosal myomata ranging in size from 1 cm to 8 cm were documented by ultrasonography. The patient is given treatment alternatives and still desires childbearing. A myomectomy is indicated and the abdominal approach is recommended because of the location of the fibroids. An exploratory laparotomy is performed. An incision is made in the overlying serosa and myometrium down to the level of the fibroids. Twelve fibroids are removed through a complex interconnected incision. The myometrial defect is closed in multiple layers. The serosa is closed with fine suture to try to decrease the rise of post operative adhesion formation. The abdominal wall is closed in a routine fashion. Following hospital discharge she receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

Under general anesthesia the abdomen is entered through a midline incision. An exploratory laparotomy is performed. The fibroid is identified. An incision is made in the overlying serosa and myometrium down to the level of the fibroid. The fibroid is dissected free. The myometrial defect is closed in multiple layers. The serosa is closed with fine suture to try to decrease the rise of post operative adhesion formation. The abdominal wall is closed in a routine fashion.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 4 days. The patient is discharged on post op day 4 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 200 Response Rate (%): 57 (29%) Median RVW: 1425th Percentile RVW: 12 75th Percentile RVW: 15 Low: 9.9 High: 21.5Median Pre-Service Time: 60 Median Intra-Service Time: 12025th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 132 Low: 60 High: 300

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>60</u>	<u>4</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	58260	Vaginal hysterectomy	11.39
3)	56308	LAVH	13.87
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

In all elements of physician work, intra-service work for CPT 58140 substantially exceeds CPT 49000. A myomectomy requires an exploratory laparotomy, removal of myomas (frequently multiple, large fibroid tumors), and subsequent suturing of the uterus, entailing about equal time and more technical skill than an exploratory laparotomy. In addition, stress is greater for CPT 58140 due a higher risk of bleeding if multiple, large myomas must be removed.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	120 min x .06	-	7.2
SD Post-service	99214		0.88
Hospital	99232		0.88
	99231		0.51
	99238		1.06
Office	99213		0.55
	99213		<u>0.55</u>
			13.14

Note: The recommended RVUs are the average of the results of the building block approach for CPT 56309 and 58140.

Public Comments

30-Jun-95

Code: 58140

1995 RVUs: 7.61

Recommended RVUs: Inc

Ratio:

Long Descriptor: Myomectomy, excision of fibroid tumor of uterus, single or multiple (separate procedure); abdominal approach

Reference Set (y/n): N Global Period: 090 Frequency: 438 Impact:

Source: 1 Year: 92 Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58140	0	0	22.2	100	55.6	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58140	511	440	-7.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58140	84.5	88.2	1.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58140	general surgery	29.1
	obstetrics/gynecology	63.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58140	218	13.9	UTERINE LEIOMYOMA
	553	2.8	OTHER HERNIA OF ABDOMINAL CAVITY
	614	8.3	INFLAMMATORY DISEASE OF OVARY, F
	617	2.8	ENDOMETRIOSIS

Public Comments

30-Jun-95

618	8.3	GENITAL PROLAPSE
621	2.8	DISORDERS OF UTERUS, NOT ELSEWHERE
625	5.6	PAIN AND OTHER SYMPTOMS ASSOCIAT
626	2.8	DISORDERS OF MENSTRUATION AND OT

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58140							
ACOG		090	090	7.82	7.61	0.97	7.61

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58140								
ACOG	7.61	7.61	0.97	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58140								
ACOG	090	7.82		32		73		37

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58140									
ACOG		1.0	*	10	4.0		15	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
58140									
ACOG		15		INCR	7.61	ob	3		0.051

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 56605 Global Period: 000 Current RVW: .86 Recommended RVW: 1.2

CPT Descriptor: Biopsy of vulva or perineum (separate procedure); one lesion

Source and Summary of Comment to HCFA on this service: ACOG: Undervalued in comparison to CPT 54100 - total work is equivalent, but 56605 has about half as many work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year old woman reports a vulvar lesion. An examination of the vulva and perineum discloses a 0.5 cm dysplastic appearing lesion. A vulvar biopsy is warranted to evaluate the etiology of this lesion to determine the appropriate treatment.

Description of Pre-Service Work:

The vignette assumes the procedure is done on the same day as the complaint was noted. The procedure and potential complications are explained in detail and informed consent is obtained.

Description of Intra-Service Work:

The vulva is prepared with an antiseptic solution. Local anesthesia is injected surrounding the site to be biopsied. Using a scalpel or punch biopsy instrument, the lesion is incised or completely excised. Simple suturing may be required.

Description of Post-Service Work:

The biopsy site is observed for bleeding. Prescriptions for analgesics and instructions for perineal care are given to the patient. As this procedure has a 0 day global period, this completes the post-service work. The patient is asked to return for re-evaluation in 1-2 weeks. The pathology report is reviewed and discussed with the patient at that time.

SURVEY DATA:

Specialty: ACOG

Sample Size: 100 Response Rate (%): 34 Median RVW: 1.2

25th Percentile RVW: 1.09 75th Percentile RVW: 1.57 Low: .38 High: 4.0

Median Pre-Service Time: 10 Median Intra-Service Time: 15

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 20 Low: 5 High: 30

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 10

ICU: ---- ----

Other Hospital:	<u> </u>	<u> </u>
Office:	<u>15</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	11420	Excision of benign lesion .5 cm or less	1.01
2)	11421	Excision of benign lesion diameter .6 to 1 cm	1.48
3)	54100	Biopsy of penis-cutaneous	1.90
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Total physician work for CPT56605 is equivalent to CPT11420, 11421 and 54100, so the survey median seemed appropriate.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Public Comments

30-Jun-95

Code: 56605

1995 RVUs: 0.86

Recommended RVUs: 1.90

Ratio:

Long Descriptor: Biopsy of vulva or perineum (separate procedure); one lesion

Reference Set (y/n): N

Global Period: 000

Frequency: 19,275

Impact: 20046

Source: 5

Year: 94

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment: AAD, ASRM 2

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
56605	44.7	7.6	4.8	99.3	6.7	0.2	0.6	12.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
56605	.	20172	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
56605	.	3.8	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
56605	general surgery	2.6
	general/family practice	2
	group practices	2.3
	obstetrics/gynecology	90.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
56605	184	1.3	MALIGNANT NEOPLASM OF OTHER AND
	221	1.3	BENIGN NEOPLASM OF OTHER FEMALE
	616	5.3	INFLAMMATORY DISEASE OF CERVIX, V

Public Comments

30-Jun-95

624	6.9	NONINFLAMMATORY DISORDERS OF VU
625	1	PAIN AND OTHER SYMPTOMS ASSOCIAT
627	2.7	MENOPAUSAL AND POSTMENOPAUSAL
701	2.2	OTHER HYPERTROPHIC AND ATROPHIC

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
56605							
ACOG			000		0.86		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
56605								
ACOG	0.62	0.86			1.39	1.00	1.90	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
56605								
ACOG	000							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
56605									
ACOG									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
56605									
ACOG				1.90	0.86				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 56606 Global Period: 000 Current RVW: .44 Recommended RVW: .55

CPT Descriptor: Biopsy of vulva or perineum (separate procedure); each additional lesion

Source and Summary of Comment to HCFA on this service: ACOG: Undervalued in comparison to CPT 54100 (see CPT 56605)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: No survey. See CPT56605.

Description of Pre-Service Work:

The vignette assumes the procedure is done on the same day as the complaint was noted. The procedure and potential complications are explained in detail and informed consent is obtained.

Description of Intra-Service Work:

The vulva is prepared with an antiseptic solution. Local anesthesia is injected surrounding the multiple sites to be biopsied. Using a scalpel or punch biopsy instrument, each lesions is incised or completely excised. Suturing the defects may be required.

Description of Post-Service Work:

The biopsy sites are observed for bleeding. The patient is asked to return for reevaluation in 1-2 weeks. Prescriptions for analgesics and instructions for perineal care are given to the patient. As this procedure has a 0 day global period, this completes the post-service work. The patient is asked to return for re-evaluation in 1-2 weeks. The pathology report is reviewed and discussed with the patient at that time.

SURVEY DATA: No Survey

Specialty: ACOG

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time: _____ Total Time _____ Number of Visits _____

Day of Procedure: _____

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)			
2)			
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Work of 56606 is equivalent to CPT11420, 11421 and 59400.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Recommended RVU is half the recommended value for CPT56605, consistent with multiple procedure payment rules.

Public Comments

Code: 56606

1995 RVUs: 0.43

Recommended RVUs: Inc

Ratio:

Long Descriptor: Biopsy of vulva or perineum (separate procedure); each separate additional lesion

Reference Set (y/n): N Global Period: 000 Frequency: 2,461 Impact:

Source: 7 Year: 93 Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment: AAD, ASRM 2

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
56606	37.2	5.8	4.7	98.8	10.5	0	0	9.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
56606		2552	

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
56606		10.1	

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
56606	general surgery	4.4
	general/family practice	2.4
	group practices	2
	obstetrics/gynecology	88.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
56606	184	4.4	MALIGNANT NEOPLASM OF OTHER AND
	221	1.5	BENIGN NEOPLASM OF OTHER FEMALE
	616	4.4	INFLAMMATORY DISEASE OF CERVIX, V

Public Comments

30-Jun-95

622	1.5	NONINFLAMMATORY DISORDERS OF CE
624	5.5	NONINFLAMMATORY DISORDERS OF VU
627	2.3	MENOPAUSAL AND POSTMENOPAUSAL
629	1.2	OTHER DISORDERS OF FEMALE GENITA
701	2	OTHER HYPERTROPHIC AND ATROPHIC

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
56606							
ACOG			000		0.43		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
56606								
ACOG	0.32	0.43			1.34	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notatw	Pret	Svdpre	ltime	Notett	Imppt
56606								
ACOG	000							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
56606									
ACOG									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
56606									
ACOG				INCR	0.43				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 56633 Global Period: 090 Current RVW: 12.15 Recommended RVW: 17.95

CPT Descriptor: Vulvectomy, radical; complete

Source and Summary of Comment to HCFA on this service: ACOG: Undervalued in comparison to CPT 19240 - pre-service work is similar, intra-service somewhat greater for 19240, post-service work greater for 56633, but 56633 has lower work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 77 year old woman has been evaluated for a large vulvar lesion involving both labia, including the clitoris. A biopsy revealed a well-differentiated verrucous carcinoma. A complete radical vulvectomy is indicated and performed in this patient due to the extent of disease. After recovery in the hospital, the patient receives the usual follow-up office care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

A radical vulvectomy is performed using a scalpel or cautery. The specimen includes the labia majora, labia minora and clitoris to the level of fascia. The specimens are identified and sent to the pathologist. The surrounding skin and subcutaneous tissue is mobilized. The closure is a primary closure and drains may be placed.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding, but this patient may be discharged with foley and drains in place. The physician visits the patient in the hospital for 7 days. The patient is discharged on post op day 7 with instructions for follow-up care. The patient is reevaluated three times postoperatively.

SURVEY DATA:Specialty: ACOGSample Size: 112 Response Rate (%): 52 Median RVW: 1525th Percentile RVW: 14 75th Percentile RVW: 17.21 Low: 12 High: 34Median Pre-Service Time: 60 Median Intra-Service Time: 12025th Percentile Intra-Svc Time: 95 75th Percentile Intra-Svc Time: 180 Low: 60 High: 240

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>25</u>	<u>1</u>
Other Hospital:	<u>100</u>	<u>7</u>
Office:	<u>50</u>	<u>3</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	19240	Mastectomy, modified, radical	14.71
2)	14041	Adjacent tissue transfer 1.1 to 3.0 sq cm	10.74
3)	11626	Excision of malignant lesion (dia) over 4.0 cm	4.2
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Total physician work for CPT 56633 exceeds total work for CPT 19240. Intra-service work is probably greater for CPT 19240 because of the removal of axillary lymph nodes. However, the difference in intra-service work is outweighed by greater post-service work for CPT 56633. Mastectomy patients typically leave the hospital sooner than vulvectomy patients and have fewer complications related to wound healing. The wound created by a mastectomy can be closed. In contrast, after a vulvectomy has been performed not enough skin remains to close the wound, so it must remain open, making the healing process more difficult. The likelihood of infection and wound breakdown is greater with a vulvectomy because of the high level of bacteria normally present in the perineal area. Patients who have undergone a vulvectomy typically require several post-discharge office visits for perineal wound care.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	-	99215	-	1.51
Intra-service	-	120 min. x 0.060	-	7.2
SD Post	-	99233	-	1.25
Hospital	-	99233 x 2	-	2.5
	-	99232 x 2	-	1.76
Office	-	99231 x 2	-	1.02
	-	99238	-	1.06
	-	99213 x 3	-	<u>1.65</u>
				17.95

Note: Data from the 1992 National Hospital Discharge Survey indicates that vulvectomy patients have an average hospital stay of 6.5 days, while mastectomy patients average length of stay is 3.3 days.

Public Comments

30-Jun-95

Code: 56633

1995 RVUs: 12.15

Recommended RVUs: Inc

Ratio:

Long Descriptor: Vulvectomy, radical, complete;

Reference Set (y/n): N

Global Period: 090

Frequency: 151

Impact:

Source: 7

Year: 95

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
56633	66.7	66.7	0	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
56633	.	166	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
56633	.	94	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
56633	general surgery	10.8
	group practices	3.6
	hematology/oncology	2.4
	obstetrics/gynecology	79.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
56633	184	25	MALIGNANT NEOPLASM OF OTHER AND

Harvard Data:

Public Comments30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
56633							
ACOG			090		12.15		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
56633								
ACOG	13.28	12.48			0.94	0.97	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
56633								
ACOG	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
56633									
ACOG									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
56633									
ACOG				INCR	12.15				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 57270 Global Period: 090 Current RVW: 7.36 Recommended RVW: 13.19

CPT Descriptor: Repair of enterocele, abdominal approach

Source and Summary of Comment to HCFA on this service: ACOG: Requires greater mental effort, technical skill and stress than CPT 49000, but has lower work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70 year old female complains of a "bulge" in the vaginal area. She has had a hysterectomy with removal of tubes and ovaries 20 years prior to this time. Examination reveals an enterocele. The patient undergoes repair of this defect by the abdominal approach. She is discharged home on the fourth post operative day and is released to regular activities after her six weeks check-up.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status.

Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

The abdomen is entered and explored. The enterocele defect is located in the pelvis. The defect is repaired by one of several techniques that essentially obliterates the cul-de-sac. Often-times excision of the enterocele sac is necessary. Hemostasis is secured at the end of the case and the abdomen is closed. A foley catheter is placed to promote gravity drainage.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 4 days. The patient is discharged on post op day 4 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 100 Response Rate (%): 31 Median RVW: 11.325th Percentile RVW: 9.83 75th Percentile RVW: 12.69 Low: 9.15 High: 16Median Pre-Service Time: 55 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 55 High: 150

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>37</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>60</u>	<u>4</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	57840	MMK	9.78
3)	58260	Vaginal hysterectomy	11.39
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 57270 entails greater mental effort, technical skill, and stress than CPT 49000. The surgery is technically difficult because the typical patient has adhesions from previous surgery. In addition, stress is high due to the risk of injury to the bowel or ureters.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	-	99215	-	1.51	
Intra-service	-	80 min. x 0.075	-	6.0	
*SD Post	-	99232	-	.88	Switch to hosp. service of 30 min.
Hospital	-	99233	-	1.25	
		99232	-	.88	
		99231	-	.51	
		99238	-	1.06	
Office	-	99213	-	.55	
		99213	-	<u>.55</u>	
				13.19	

Public Comments

30-Jun-95

Code: 57270

1995 RVUs: 7.36

Recommended RVUs: Inc

Ratio:

Long Descriptor: Repair of enterocele, abdominal approach (separate procedure)

Reference Set (y/n): N

Global Period: 090

Frequency: 1,502

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ASRM 2

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
57270	30.6	2.4	2.4	100	7.1	0	0	12.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
57270	1491	1643	5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
57270	94.3	95.5	0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
57270	general surgery	7.1
	obstetrics/gynecology	83.1
	urology	7.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
57270	218	1.2	UTERINE LEIOMYOMA
	553	1.2	OTHER HERNIA OF ABDOMINAL CAVITY
	614	2.3	INFLAMMATORY DISEASE OF OVARY, F
	618	39	GENITAL PROLAPSE

Public Comments

30-Jun-95

620	2.3	NONINFLAMMATORY DISORDERS OF OV
625	7	PAIN AND OTHER SYMPTOMS ASSOCIAT
789	1.2	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
57270							
ACOG		090	090	7.59	7.36	0.97	7.36

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
57270								
ACOG	7.36	7.36	0.97	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
57270								
ACOG	090	7.59		26		59		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
57270									
ACOG		1.0	*	10	3.5		15	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
57270									
ACOG		15		INCR	7.36	ob	3		0.057

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 57280 Global Period: 090 Current RVW: 8.35 Recommended RVW: 15.42

CPT Descriptor: Colpopexy, abdominal approach

Source and Summary of Comment to HCFA on this service: ACOG: Requires more mental effort, technical skill, and stress than CPT 49000, but has lower work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63 year old sexually active G5P5 underwent abdominal hysterectomy twenty years ago for leiomyomata. She developed a symptomatic cystocele and rectocele and was treated with anterior and posterior repair 3 years ago. Now she is being evaluated for discomfort and tissue prolapsing through the introitus. Examination documents prolapse of the vaginal vault through the introitus and good anterior and posterior support. At surgery and abdominal incision is made through all layers. The vagina is identified. The bladder is dissected off the anterior vaginal wall and the posterior wall is freed. The peritoneum overlying the sacrum is incised and the periosteum cleared. Using a variety of techniques the vagina is secured to the periosteum of the sacral promontory. Edges of the "sling" are assessed to prevent internal hernia formation. The abdomen is closed in layers. The patient is observed in the hospital for an average of 4-6 days. She is discharged after normal bowel function has returned and receives routine follow-up care in the office during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

At surgery an abdominal incision is made through all layers. After the abdominal cavity is explored, the vagina is identified. The bladder is dissected off the anterior vaginal wall and the posterior wall is freed. The peritoneal overlying the sacrum is incised and the periosteum cleared. Using a variety of techniques the vagina is secured to the periosteum of the sacral promontory. Edges of the "sling" are assessed to prevent internal hernia formation. The abdomen is closed in layers.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 5 days. The patient is discharged on post op day 5 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 100 Response Rate (%): 36 Median RVW: 14.125th Percentile RVW: 11.78 75th Percentile RVW: 16 Low: 9.78 High: 22.5Median Pre-Service Time: 60 Median Intra-Service Time: 11525th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 120 Low: 60 High: 300

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>67</u>	<u>5</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	51840	MMK	9.78
3)	58260	Vaginal hysterectomy	11.39
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 57280 requires more total physician work than CPT 49000. During the intra-service period, CPT 57280 requiring more mental effort and technical skill. The colpexy includes an exploratory laparotomy and lysis of adhesions to locate the vagina. A piece of fascia or synthetic graft is then transected and reimplanted to support the vagina. The bowel must be mobilized to allow fixation. Stress is high due to the risk of injury to bowel and ureters. In addition, these patients are generally older, have more frequent comorbidities, and experience more post-operative complications than the typical patients for CPT 49000, 51840, and 58260.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	-	99215	-	1.51
Intra-service	-	98 min x 0.075	-	7.35
SD Post	-	99233		1.25
Hospital	-	99233	-	1.25
		99232	-	.88
		99231 x 2	-	1.02
		99238	-	1.06
Office	-	99213 x 2	-	<u>1.1</u>
				15.42

Public Comments

30-Jun-95

Code: 57280

1995 RVUs: 8.35

Recommended RVUs: Inc

Ratio:

Long Descriptor: Colpopexy, abdominal approach

Reference Set (y/n): N

Global Period: 090

Frequency: 2,427

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ASRM 2

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
57280	33.3	2.9	5.8	100	4.3	0	0	30.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
57280	2281	2696	8.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
57280	93.4	95.2	0.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
57280	general surgery	9.9
	obstetrics/gynecology	78.7
	urology	7.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
57280	553	1.1	OTHER HERNIA OF ABDOMINAL CAVITY
	614	1.1	INFLAMMATORY DISEASE OF OVARY, F
	618	34.8	GENITAL PROLAPSE
	625	6.9	PAIN AND OTHER SYMPTOMS ASSOCIAT

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfawk92
57280							
ACOG		090	090	8.58	8.35	0.97	8.35

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
57280								
ACOG	8.35	8.35	0.97	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
57280								
ACOG	090	8.58		36		67		48

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
57280									
ACOG		1.0		10	4.0		15	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
57280									
ACOG		15		INCR	8.35	ob	3		0.056

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 57289 Global Period: 090 Current RVW: 6.4 Recommended RVW: 12.29

CPT Descriptor: Pereya procedure, including anterior colporrhaphy

Source and Summary of Comment to HCFA on this service: ACOG: Undervalued in comparison to CPT 58145 - CPT 57289 includes all services provided with CPT 51845, plus an anterior colporrhaphy (CPT 57240), but has lower work RVUs than CPT 58145.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year old female reported symptoms of stress urinary incontinence. Examination revealed a large cystocele with loss of urethro-vesicle support. Formal cystometric evaluation reveals stress urinary incontinence, a normal bladder volume, and no evidence of detrusor instability. The patient undergoes a Pereya procedure with anterior colporrhaphy. She does well post operatively and is discharged on the third post-op day. She is unable to void adequately at the time of discharge, therefore is instructed in self-catheterization. She is seen weekly in the office until she voids adequately approximately 14 days after surgery. She is seen 6 weeks post-op to assess her healing and recovery and is released to her usual activities.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

The vaginal mucosa overlying the bladder is incised and dissected off of the bladder. Through two small lower abdominal incisions a suture is placed retropubically and looped around the neck of the bladder where it joins the urethra. This suture is anchored to the abdominal wall fascia thus suspending the urethrovesicle angle (Pereyra procedure). The peri-vesicle fascia is then plicated in the midline and the previously incised vaginal mucosa is re-approximated thus completing the anterior colporrhaphy. A foley is placed for gravity drainage and a vaginal pack is also placed. The small abdominal incisions are closed.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated three times post operatively.

SURVEY DATA:Specialty: ACOGSample Size: _____ Response Rate (%): 30 Median RVW: 10.825th Percentile RVW: 10 75th Percentile RVW: 12 Low: 7.5 High: 14Median Pre-Service Time: 60 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 100 Low: 45 High: 120

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>35</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>50</u>	<u>3</u>
Office:	<u>45</u>	<u>3</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	51845	Vesical needle suspension (Pereya)	9.06
			> 11.76
2)	57240	Anterior colporrhaphy	5.39
3)	51840	MMK	9.78
4)	51860	Cystorrhaphy - simple	11.17

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 57289 is equivalent to CPT 51845, plus 57240. However, since performing the Pereya procedure and the anterior colporrhaphy together requires both an abdominal and vaginal approach through separate incisions, strict application of the multiple procedure payment rule (which would dictate that half of the work RVUs for 57240 be added to the work RVUs for 51845) does not make sense. In this instance, the additional work required to perform the anterior colporrhaphy with the Pereya procedure is closer to 60 percent of the work RVUs for 57240.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	-	99215	-	1.51
Intra-service	-	90 x 0.06	-	5.40
SD Post	-	99232	-	.88
Hospital	-	99233	-	1.25
		99232	-	.88
		99238	-	1.06
Office	-	99213	-	.55
		99212 x 2	-	<u>.76</u>
				12.29

Public Comments

30-Jun-95

Code: 57289

1995 RVUs: 6.4

Recommended RVUs: Inc

Ratio:

Long Descriptor: Pereyra procedure, including anterior colporrhaphy

Reference Set (y/n): N

Global Period: 090

Frequency: 1,051

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ASRM 2

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
57289	25.9	7.4	16	100	3.7	0	0	20

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
57289	1281	1182	-3.9

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
57289	94.3	94.4	0

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
57289	obstetrics/gynecology	43.5
	urology	53.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
57289	218	1.9	UTERINE LEIOMYOMA
	618	19.4	GENITAL PROLAPSE
	625	13	PAIN AND OTHER SYMPTOMS ASSOCIAT
	788	3.7	SYMPTOMS INVOLVING URINARY SYST

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
57289							
ACOG		090	090	6.55	6.40	0.98	6.40

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
57289								
ACOG	6.40	6.40	0.98	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
57289								
ACOG	090	6.55		27	*	56		39

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvvis	Offvis
57289									
ACOG	*	1.0	*	10	2.5	*	15	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
57289									
ACOG	*	15		INCR	6.40	ob	3		0.049

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 57305 Global Period: 090 Current RVW: 8.69 Recommended RVW: 14.74

CPT Descriptor: Closure of rectovaginal fistula; abdominal approach

Source and Summary of Comment to HCFA on this service: ACOG: Technical skill and mental effort required exceed skill required for CPT 49000, but 57305 has slightly lower work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year old patient complained of leaking stool from her vagina 2 weeks following a TAH-BSO for severe endometriosis. The work-up reveals a rectovaginal fistula at approximately 15 cm in the rectosigmoid. You determine that an abdominal surgical approach will yield the best result. She now undergoes closure of the rectovaginal fistula. Following hospital discharge, she receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

A skin incision is made and carefully carried by layers until the peritoneal cavity is entered. The abdominal cavity is explored and the bowel packed out of the pelvis. The sigmoid is mobilized. The rectovaginal septum is entered and the vagina is bluntly and sharply dissected from the rectum. The fistula is identified and excised. The defect in the rectosigmoid is closed using staples or sutures in a transverse fashion. The defect in the vagina is closed. Once hemostasis is obtained, a drain may be brought out through the vagina or a separate site on the anterior abdominal wall. The bowel is placed back into the pelvis and the closure is in layers. Antibiotics are usually administered intraoperatively.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 6 days. The patient is discharged on post op day 6 with instructions for follow-up care. The patient is reevaluated three times post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 212 Response Rate (%): 53 (25%) Median RVW: 15.7525th Percentile RVW: 13.37 75th Percentile RVW: 17.98 Low: 11 High: 30Median Pre-Service Time: 60 Median Intra-Service Time: 12025th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 150 Low: 70 High: 240

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>----</u>	<u>-----</u>
Other Hospital:	<u>77</u>	<u>6</u>
Office:	<u>32</u>	<u>3</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	51900	Vesical vaginal fistula closure	11.67
2)	44140	Colectomy - partial with anastomosis	16.97
3)	49000	Exploratory laparotomy	8.99
4)	45800	Closure of recto vesical fistula	12.95

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 57305 includes an exploratory laparotomy (CPT 49000), entering the rectovaginal septum, excising fistula tract, and closing the defect in the vagina and rectum. Often a flap of tissue is transplanted in between the vagina and rectum to protect the repair. The technical skill and mental effort/judgment required to perform this repair greatly exceed the skill required to perform CPT 49000. Total physician work for CPT 57305 is slightly less than the work required for CPT 51900 and 44140.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	-	99215	-	1.51
Intra service	-	120 x 0.060	-	7.2
SD Post	-	99233	-	1.25
Hosp.	-	99232	-	.88
		99231 x 3	-	1.53
		99238	-	1.06
Office	-	99213	-	.55
		99212 x 2	-	<u>.76</u>
				14.74

Public Comments

30-Jun-95

Code: 57305

1995 RVUs: 8.69

Recommended RVUs: Inc

Ratio:

Long Descriptor: Closure of rectovaginal fistula; abdominal approach

Reference Set (y/n): N

Global Period: 090

Frequency: 278

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASCRS

Societies Wishing to Comment: ASRM 2

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
57305	54.5	9.1	0	100	0	0	9.1	9.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
57305	253	311	11

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
57305	98.4	99.4	0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
57305	colon and rectal surger	11.6
	general surgery	68.5
	group practices	2.6
	obstetrics/gynecology	7.7
	thoracic surgery	3.2
	vascular surgery	3.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
57305	562	13.6	DIVERTICULA OF INTESTINE

Public Comments

30-Jun-95

568	2.3	OTHER DISORDERS OF PERITONEUM
619	22.7	FISTULA INVOLVING FEMALE GENITAL
996	2.3	COMPLICATIONS PECULIAR TO CERTAI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
57305							
ACOG		090	090	8.82	8.69	0.99	8.69

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
57305								
ACOG	8.69	8.69	0.99	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
57305								
ACOG	090	8.82		33	*	84		39

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
57305									
ACOG	*	1.0	*	10	3.5	*	15	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
57305									
ACOG	*	15		INCR	8.69	ob	3		0.051

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 57307 Global Period: 090 Current RVW: 10.05 Recommended RVW: 16.88

CPT Descriptor: Closure of rectovaginal fistula; abdominal approach; with concomitant colostomy

Source and Summary of Comment to HCFA on this service: ACOG: Intra-service skill, mental effort, and stress are substantially greater for this procedure than for 49000 and post-service work is greater due to creation of the colostomy, but the difference in RVUs does not reflect the difference in work.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year old patient complains of leaking stool from her vagina 2 weeks following a TAH-BSO for severe endometriosis. The work-up reveals a rectovaginal fistula at approximately 15 cm in the rectosigmoid. You determine that an abdominal surgical approach will yield the best result.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

A skin incision is made and carefully carried by layers until the peritoneal cavity is entered. The abdominal cavity is explored and the bowel packed out of the pelvis. The sigmoid is mobilized. The rectovaginal septum is entered and the vagina bluntly and sharply dissected from the rectum. The fistula is identified and excised. The defect in the rectosigmoid is closed using staples or sutures in a transverse fashion. The defect in the vagina is closed. The operating surgeon may feel a diverting colostomy is needed to insure primary closure of the fistula or feels the risk of breakdown of the fistula repair is high. A diverting colostomy involves isolation of a loop of large bowel proximal to the fistula repair. A separate skin incision is made for the colostomy. A fascial incision is created and the loop of large bowel is brought out of the abdomen through this opening. It is fixed in place with sutures. The stoma can be matured (opened) at a separate setting postoperatively or immediately in the operating room, following closure of the other incision. Once hemostasis is obtained, a drain may be brought out through the vagina or a separate site on the anterior abdominal wall. The bowel is placed back into the pelvis and the closure is in layers. Antibiotics are usually administered intraoperatively.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated three times post operatively.

SURVEY DATA:

Specialty: ACOG NO SURVEY

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: _____

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	45825	Closure of recto-urethral fistula with colostomy	15.45
2)	45820	Closure of recto-urethral fistula without colostomy	13.31
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 57307 is equivalent to 57305 (15.34) plus 2.14 (difference between 45820 and 45825).

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Public Comments

30-Jun-95

Code: 57307

1995 RVUs: 10.05

Recommended RVUs: Inc

Ratio:

Long Descriptor: Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy

Reference Set (y/n): N Global Period: 090 Frequency: 47 Impact:

Source: 1 Year: 92 Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASCRS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
57307	50	50	0	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
57307	33	46	18.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
57307	100	100	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
57307	general surgery	91.3
	group practices	4.3
	obstetrics/gynecology	4.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
57307	154	12.5	MALIGNANT NEOPLASM OF RECTUM, RE
	182	12.5	MALIGNANT NEOPLASM OF BODY OF U
	562	12.5	DIVERTICULA OF INTESTINE
	619	12.5	FISTULA INVOLVING FEMALE GENITAL

Public Comments

30-Jun-95

623	12.5	NONINFLAMMATORY DISORDERS OF VA
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
57307							
ACOG		090	090	10.15	10.05	0.99	10.05

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
57307								
ACOG	10.05	10.05	0.99	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ftime	Notett	Imppt
57307								
ACOG	090	10.15		37	*	120		39

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
57307									
ACOG	*	1.0	*	10	4.0	*	15	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
57307									
ACOG	*	15		INCR	10.05	ob	3		0.043

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 57400 Global Period: 000 Current RVW: 0.83 Recommended RVW: 2.27

CPT Descriptor: Dilation of vagina under anesthesia

Source and Summary of Comment to HCFA on this service: ACOG: Undervalued in comparison to CPT 99221. Requires pre-service and post-service work at least equivalent to CPT 99221 or 99222, as well as the work and risk of the procedure itself.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year old woman who had a TAH-BSO and radiation treatment for uterine cancer has a markedly stenotic vaginal opening which prevents coitus. The patient's vagina is dilated under anesthesia to relieve obstruction. Arrangements are made for the post procedure follow-up.

Description of Pre-Service Work:

Informed consent is obtained and the procedure is explained to the patient.

Description of Intra-Service Work:

Under general anesthesia a pelvic exam is performed. A series of progressively larger dilators are introduced through the introitus to dilate the vagina.

Description of Post-Service Work:

Following recovery from anesthesia and observation for reaction to the procedure, the patient is released to home with instructions about follow-up care, and possible complications.

SURVEY DATA:

Specialty: ACOG

Sample Size: 100 Response Rate (%): 35 (35%) Median RVW: 2.95

25th Percentile RVW: 1.25 75th Percentile RVW: 4.0 Low: 1 High: 5.95

Median Pre-Service Time: 30 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 14 75th Percentile Intra-Svc Time: 30 Low: 5 High: 45

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 30

ICU: ---- ----

Other Hospital: 10 1

Office: 15 1

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	57505	Endocervical curettage	1.09
2)	59820	Surgical treatment missed abortion - 1st trimester	3.73
3)	99222	Initial hospital care	1.84
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 57400 includes pre- and post-operative care equivalent to CPT 99222, plus intra-service work approximately equal to half the work of CPT 57505.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99214	-	.94
Intra-service	15 min x 0.03	-	.45
SD Post-service	99232	-	<u>.88</u>
			2.27

Public Comments

30-Jun-95

Code: 57400 1995 RVUs: 0.83 Recommended RVUs: Inc Ratio:

Long Descriptor: Dilation of vagina under anesthesia

Reference Set (y/n): N Global Period: 000 Frequency: 186 Impact:

Source: 2 Year: 92 Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment: AOA, APSA, ASRM 2

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
57400	66.7	33.3	33.3	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
57400	196	178	-4.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
57400	29.6	29.2	-0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
57400	general surgery	15.7
	general/family practice	19.1
	group practices	5.6
	obstetrics/gynecology	48.3
	urology	7.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
57400	285	8.3	OTHER AND UNSPECIFIED ANEMIAS
	623	16.7	NONINFLAMMATORY DISORDERS OF VA

Public Comments

30-Jun-95

625	8.3	PAIN AND OTHER SYMPTOMS ASSOCIAT
627	8.3	MENOPAUSAL AND POSTMENOPAUSAL
789	16.7	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
57400							
ACOG		000	000	0.92	0.83	0.90	0.83

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
57400								
ACOG	0.83	0.83	0.90	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
57400								
ACOG	000	0.92		11		18		11

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
57400									
ACOG		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
57400									
ACOG		0		INCR	0.83	ob	3		0.025

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 57410 Global Period: 000 Current RVW: 0.59 Recommended RVW: 1.75

CPT Descriptor: Pelvic examination under anesthesia

Source and Summary of Comment to HCFA on this service: ACOG: Undervalued in comparison to CPT 99221. Requires pre- and post-service work at least equivalent to CPT 99221 or 99222, as well as the work and risk of the procedure itself.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old Gravida 0 female with oligomenorrhea and severe mental retardation is referred for gynecologic evaluation. Her caregivers report seeing blood on her underclothes 1-2 times every week between periods. The patient is combative and cannot cooperate with having a bi-manual examination or for obtaining a pap smear. It has been four years since the last attempted gynecologic examination. Under general anesthesia, a pelvic examination and pap smear are obtained. The patient is returned to the facility from which she was referred.

Description of Pre-Service Work:

Informed consent is obtained and the procedure is explained to the patient's family. The physician reviews the record to ascertain medical status and waits for anesthesia induction and positioning of the patient.

Description of Intra-Service Work:

Under general anesthesia a pap smear, evaluation of external and internal genitalia and bimanual exam are performed.

Description of Post-Service Work:

Following recovery from anesthesia and observation for reaction to the procedure, the patient is released to home with instructions about follow-up care, and possible complications.

SURVEY DATA:

Specialty: ACOG

Sample Size: 100 Response Rate (%): 39 (39%) Median RVW: 2.72

25th Percentile RVW: 1.2 75th Percentile RVW: 3.35 Low: .5 High: 5.72

Median Pre-Service Time: 30 Median Intra-Service Time: 15

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 20 Low: 5 High: 40

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 25

ICU: ---- ----

Other Hospital:	<u>10</u>	<u>1</u>
Office:	<u>15</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	57505	Endocervical curettage	1.09
2)	99215	Level 5 established patient visit	1.51
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 57410 requires total evaluation and management services (pre- and post-service) equivalent to CPT 99215. In addition, assuming that the intra-service work of CPT 57505 accounts for 50% of the total RVUs for 57505 and that the work required to perform the pelvic examination under anesthesia is equivalent to about half the intra-service work of 57505, the survey median of 2.72 RVUs seems unreasonably high. We are therefore recommending 1.75 RVUs for this procedure.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Public Comments

30-Jun-95

Code: 57410

1995 RVUs: 0.59

Recommended RVUs: Inc

Ratio:

Long Descriptor: Pelvic examination under anesthesia

Reference Set (y/n): N

Global Period: 000

Frequency: 8,027

Impact:

Source: 2

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment: AAP, ACEP, AOA, APSA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
57410	35.3	7.2	18.9	98.7	20.2	0	0.4	12.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
57410	9033	8938	-0.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
57410	31.2	31.3	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
57410	general surgery	9
	general/family practice	17.2
	hematology/oncology	2.8
	internal medicine	10.5
	obstetrics/gynecology	34
	urology	20.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
57410	180	1.7	MALIGNANT NEOPLASM OF CERVIX UTE

Public Comments

30-Jun-95

182	2.4	MALIGNANT NEOPLASM OF BODY OF U
401	1.3	ESSENTIAL HYPERTENSION
599	1.6	OTHER DISORDERS OF URETHRA AND U
616	1.8	INFLAMMATORY DISEASE OF CERVIX, V
618	1.8	GENITAL PROLAPSE
627	4	MENOPAUSAL AND POSTMENOPAUSAL
789	1.5	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
57410							
ACOG		000	000	0.93	0.59	0.63	0.59

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
57410								
ACOG	0.59	0.59	0.63	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Hime	Notett	Imppt
57410								
ACOG	000	0.93		13		7		13

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuis	Offvis
57410									
ACOG		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
57410									
ACOG		0		INCR	0.59	ob	3		0.050

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 57415 Global Period: 000 Current RVW: .91 Recommended RVW: 2.27

CPT Descriptor: Removal of impacted vaginal foreign body (separate procedure) under anesthesia

Source and Summary of Comment to HCFA on this service: ACOG: Undervalued in comparison to CPT 42809. CPT 57415 requires greater technical skill in the intra-service period, and more post-operative work.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 6 year old female presents with a foreign body lodged in her vagina. Attempts to remove the foreign body are unsuccessful. With appropriate pre-operative assessment, the foreign body is removed under general anesthesia. Satisfactory tetanus vaccination status is confirmed. The patient's parents are given instructions and asked to return in one week.

Description of Pre-Service Work:

Informed consent is obtained and the procedure is explained to the patient's family. The physician reviews the record to ascertain medical status and waits for anesthesia induction and positioning of the patient.

Description of Intra-Service Work:

Under general anesthesia the foreign body is removed and the vaginal vault is lavaged. Simple suturing or placement of a vaginal pack may be necessary.

Description of Post-Service Work:

Following recovery from anesthesia and observation for reaction to the procedure, the patient is released to home with instructions about follow-up care, and possible complications.

SURVEY DATA:

Specialty: ACOG

Sample Size: 200 Response Rate (%): 59 (30%) Median RVW: 3.25

25th Percentile RVW: 1.51 75th Percentile RVW: 3.75 Low: .75 High: 7.0

Median Pre-Service Time: 45 Median Intra-Service Time: 15

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 5 High: 45

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 30

ICU: ---- ----

Other Hospital:	----	----
Office:	<u>15</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	42809	Removal of foreign body from pharynx	1.76
2)	31635	Bronchoscopy with removal of foreign body	3.37
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 57415 is typically performed under a general anesthetic, thus requiring a pre-operative history and physical. In contrast, CPT 42809 is performed under a local anesthetic, so the pre-service history and physical are not as extensive. The intra-service work required for CPT 57415 is approximately equivalent than the physician work of removing a foreign body from the pharynx. Safely removing an impacted foreign body from the vagina requires more technical skill and physical effort than does CPT 42809 because the foreign body is impacted. However, stress is probably higher for CPT 42809 because of the immediate risk of airway obstruction. Unlike CPT 42809, CPT 57415 also requires a post-anesthesia visit in addition to any services and the likelihood of infection is higher for CPT 57415, due to the high level of bacteria present in the normal vaginal environment. CPT 57415 is less work than CPT 31635 because it does not include the work of the bronchoscopy.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Day of service	99214	-	.94
Intra-service	15 min. 0.03	-	.45
SD Post-service	99233	-	<u>.88</u>
			2.27

Public Comments

30-Jun-95

Code: 57415

1995 RVUs: 0.91

Recommended RVUs: Inc

Ratio:

Long Descriptor: Removal of impacted vaginal foreign body (separate procedure) under anesthesia

Reference Set (y/n): N

Global Period: 010

Frequency: 179

Impact:

Source: 8

Year: 93

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment: AAP, ACEP, AOA, APSA, ASRM 2

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
57415	100	0	0	100	0	0	0	.

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
57415	.	190	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
57415	.	23.2	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
57415	general surgery	7.4
	general/family practice	7.4
	group practices	2.1
	internal medicine	2.1
	obstetrics/gynecology	73.7
	urology	6.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
57415	618	25	GENITAL PROLAPSE

Public Comments

30-Jun-95

627	25	MENOPAUSAL AND POSTMENOPAUSAL
867	25	INJURY TO PELVIC ORGANS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
57415							
ACOG			010		0.91		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
57415								
ACOG	0.91	0.91			1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
57415								
ACOG	010							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
57415									
ACOG									

Harvard Data:

Comm	Svdoftd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
57415									
ACOG				INCR	0.91				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 57540 Global Period: 090 Current RVW: 6.01 Recommended RVW: 11.94

CPT Descriptor: Excision of cervical stump, abdominal approach

Source and Summary of Comment to HCFA on this service: ACOG: Requires approximately equivalent time and significantly more mental effort, technical skill, and stress than CPT 49000, but work RVUs are lower.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year old woman had a subtotal hysterectomy for fibroids 20 years ago. She has been diagnosed with extensive cervical carcinoma-in-situ. She now undergoes excision of the cervical stump via an abdominal approach. Following discharge from the hospital she receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

A skin incision is made and carefully carried by layers until the peritoneal cavity is entered. The risk of injury to bowel is significant due to adhesions from previous surgery. The adhesions are lysed. The bowel is packed away. The sigmoid colon and bladder are usually adherent to the cervix from the dissection at the time of previous surgery. Care is taken to avoid injury to these structures. The bladder, sigmoid and rectum are carefully dissected off of the cervix. The vessels are clamped, cut and suture ligated. The cervix is removed by clamping across the vaginal cuff. The abdomen is closed in layers and dressings applied. Drains may be used.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:

Specialty: ACOG

Sample Size: 212 Response Rate (%): 55 (26%) Median RVW: 11.54

25th Percentile RVW: 10.45 75th Percentile RVW: 13 Low: 9.5 High: 17

Median Pre-Service Time: 50 Median Intra-Service Time: 75

25th Percentile Intra-Svc Time: 61 75th Percentile Intra-Svc Time: 120 Low: 45 High: 180

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>50</u>	<u>3</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	51900	Closure of vesical vaginal fistula	11.67
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 57540 requires significantly more time, mental effort and technical skill than CPT 49000. It includes an exploratory laparotomy, as well as removal of the cervical stump. The surgery is more technically demanding because of the presence of adhesions from the previous hysterectomy. In addition, the patient is typically sicker and requires more post-operative work than for either CPT 49000 or CPT 51900 because of the diagnosis of cancer.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	75 min x 0.075	-	5.63
SD Post	99233	-	1.25
Hosp.	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99213 x 2	-	<u>1.10</u>
			11.94

Public Comments

30-Jun-95

Code: 57540

1995 RVUs: 6.01

Recommended RVUs: Inc

Ratio:

Long Descriptor: Excision of cervical stump, abdominal approach;

Reference Set (y/n): N

Global Period: 090

Frequency: 84

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ASRM 2

Trends Analysis - Beneficiary Information:

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
57540	113	98	-6.9

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
57540	84.1	89.8	2.9

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
57540	general surgery	32.7
	internal medicine	2
	obstetrics/gynecology	63.3
	urology	2

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
57540							

Public Comments

30-Jun-95

ACOG	090	090	6.36	6.01	0.94	6.01
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
57540								
ACOG	6.01	6.01	0.94	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
57540								
ACOG	090	6.36		26	*	59		38

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
57540									
ACOG	*	1.0	*	10	3.5	*	15	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
57540									
ACOG	*	15		INCR	6.01	ob	3		0.037

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 57545 Global Period: 090 Current RVW: 6.63 Recommended RVW: 14.93

CPT Descriptor: Excision of cervical stump, abdominal approach; with pelvic floor repair

Source and Summary of Comment to HCFA on this service: ACOG: Requires approximately equivalent time and significantly more mental effort, technical skill, and stress than CPT 49000, but work RVUs are lower.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year old woman had a subtotal hysterectomy for fibroids 20 years ago. She has been diagnosed with extensive cervical carcinoma-in-situ. Her pre-operative evaluation also revealed a symptomatic enterocele with pelvic pressure and dyspareunia. She now undergoes excision of the cervical stump and repair of the enterocele via an abdominal approach. Following discharge from the hospital she receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

A skin incision is made and carefully carried by layers until the peritoneal cavity is entered. The risk of injury to bowel is significant due to adhesions from previous surgery. The adhesions are lysed. The bowel is packed away. The sigmoid colon and bladder are usually adherent to the cervix from the dissection at the time of previous surgery. Care is taken to avoid injury to these structures. The bladder, sigmoid and rectum are carefully dissected off of the cervix. The vessels are clamped, cut and suture ligated. The cervix is removed by clamping across the vaginal cuff. Following removal of the cervix, the pelvic floor is repaired by obliterating the cul-de-sac with sutures placed anterior to posterior or circumferentially from the vaginal vault to the rectosigmoid. The abdomen is closed in layers and dressings applied. Drains may be used.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 212 Response Rate (%): 53 (25%) Median RVW: 12.325th Percentile RVW: 11.18 75th Percentile RVW: 14.31 Low: 10.5 High: 20Median Pre-Service Time: 60 Median Intra-Service Time: 12025th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 150 Low: 60 High: 240Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 40ICU: --- ---Other Hospital: 60 3Office: 30 2**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	51900	Closure of vesical vaginal fistula	11.67
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 57545 requires significantly more time, mental effort and technical skill than CPT 49000. It includes an exploratory laparotomy, as well as removal of the cervical stump and pelvic floor repair. The surgery is more technically demanding because of the presence of adhesions from the previous hysterectomy. In addition, the patient is typically sicker and requires more post-operative work than for either CPT 49000 or CPT 51900 because of the diagnosis of cancer.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The elements of work are identical to those for CPT 57540, except that CPT 57545 requires approximately 25 additional minutes of intra-service time to perform the pelvic floor repair. At 0.075 RVUs per minute this results in 1.87 additional RVUs for the pelvic floor repair (13.06 for CPT 57540 = 1.87 = 14.93 RVUs)

Public Comments

30-Jun-95

Code: 57545

1995 RVUs: 6.63

Recommended RVUs: Inc

Ratio:

Long Descriptor: Excision of cervical stump, abdominal approach; with pelvic floor repair

Reference Set (y/n): N

Global Period: 090

Frequency: 22

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ASRM 2

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
57545	43	28	-19.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
57545	34.9	50	7.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
57545	general surgery	14.3
	obstetrics/gynecology	78.6
	urology	7.1

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
57545							
ACOG		090	090	7.88	6.63	0.84	6.63

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
57545								
ACOG	6.63	6.63	0.84	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
57545								
ACOG	090	7.88		31	*	86		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
57545									
ACOG	*	1.0	*	10	4.0	*	15	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	hwput
57545									
ACOG	*	15		INCR	6.63	ob	3		0.037

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58120 Global Period: 010 Current RVW: 2.45 Recommended RVW: 3.56

CPT Descriptor: Dilation and curettage, diagnostic or therapeutic (non-obstetric)

Source and Summary of Comment to HCFA on this service: ACOG: Typical patient undergoing 58120 has become more difficult since time when Harvard data on which the current RVUs are based were collected.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year old G0-P0 woman with postmenopausal undergoes a D&C following a failed endometrial biopsy due to rigid stenotic cervix. She receives routine follow-up care in the office during the 10 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

A pelvic examination is performed. A single toothed tenaculum is applied to the anterior lip of the cervix. An endocervical curettage is performed. The uterus is sounded. Dilatation of the cervix is followed by an endometrial curettage. Because of the tight cervical canal, the dilatation may be more difficult thereby increasing the risk of perforation and bleeding.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 1 day. The patient is discharged on post op day 1 with instructions for follow-up care. The patient is reevaluated once post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 312 Response Rate (%): 70 (22%) Median RVW: 3.7325th Percentile RVW: 3.36 75th Percentile RVW: 4.0 Low: 1.5 High: 7.0Median Pre-Service Time: 35 Median Intra-Service Time: 2525th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 30 Low: 7.5 High: 30

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>27</u>	
ICU:	<u>---</u>	<u>---</u>
Other Hospital:	<u>15</u>	<u>1</u>
Office:	<u>20</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99215	Level 5 established patient office visit	1.51
2)	59820	Surgical treatment of missed abortion-1st trimester	3.73
3)	99213	Level 3 established patient office visit	.55
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Total time is greater than 99215. More risk than 99215 because of possibility of uterus perforation. Technical skill greater than for 59820.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Same-day pre and post-service work = 99215	=	1.51
Intra-service		
.25 minutes X 0.06 RVUs per minute	=	1.50
Office Post-Service = 99213	=	<u>.55</u>
		3.56

Note: The typical patient undergoing a D&C has changed since 1987 when the initial work RVUs for this procedure were established, due to the availability of other, preferred diagnostic techniques such as endometrial sampling (CPT 58100) and diagnostic hysteroscopy (CPT 56350). The result of the increasing use of these substitute technologies is that CPT 58120 is reserved for patients for whom other diagnostic procedures have failed (for example, CPT 58100 could not be performed because of a stenotic cervix) or in whom conditions such as polyps, hyperplasia, or dysfunctional bleeding have been found. Any of these conditions increase the technical difficulty of the procedure and the risk of uterine perforation or hemorrhage. The typical patient now is also more likely to have comorbid conditions that increase the medical risk of the procedure. As a result, the physician work associated with CPT 58120 has increased, making the current procedure undervalued in comparison to the RVUs established for CPT 58120 with data from Phase I of the Harvard study.

Data that directly support the argument that many patients who would previously have received a D&C undergo other diagnostic procedures are scarce. Medicare claims data do, however, suggest that this substitution has occurred. Between 1986 and 1991 Medicare claims submitted by ob-gyns for CPT 58120 increased 17%, from 39,784 to 46,658. Over the same time period, claims submitted for CPT 58100 increased 212% from 13,447 to 42,042 and claims for CPT 56350 increased by 272% from 1,953 to 7,258.

Public Comments

30-Jun-95

Code: 58120

1995 RVUs: 2.45

Recommended RVUs: Inc

Ratio:

Long Descriptor: Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)

Reference Set (y/n): N Global Period: 010 Frequency: 43,311 Impact:

Source: 1 Year: 92 Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment: AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58120	33.3	6.8	11.9	99.7	13.8	0.3	0.4	14.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58120	59433	48150	-10

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58120	22.5	21.9	-0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58120	general surgery	6.5
	general/family practice	4.3
	group practices	2
	obstetrics/gynecology	86.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58120	182	1	MALIGNANT NEOPLASM OF BODY OF U
	218	1	UTERINE LEIOMYOMA
	621	3.5	DISORDERS OF UTERUS, NOT ELSEWHERE

Public Comments

30-Jun-95

622	1.8	NONINFLAMMATORY DISORDERS OF CE
626	3.3	DISORDERS OF MENSTRUATION AND OT
627	15.6	MENOPAUSAL AND POSTMENOPAUSAL

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58120							
ACOG		010	010	2.42	2.45	1.01	2.45

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58120								
ACOG	2.45	2.45	1.01	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
58120								
ACOG	010	2.42		22		13		29

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58120									
ACOG		0.5		5	0.0		0	0.0	1.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58120									
ACOG		5		INCR	2.45	ob	n		0.061

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58150 Global Period: 090 Current RVW: 13 Recommended RVW: 16.33

CPT Descriptor: Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)

Source and Summary of Comment to HCFA on this service: ACOG: Typical patient undergoing 58150 has become more difficult since time when Harvard data on which the current RVUs are based were collected.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52 year old G0 woman has been evaluated for a large pelvic mass. Ultrasound demonstrated bilateral complex solid and cystic adnexal masses and a leiomyomatous uterus. CA125 is elevated. She now undergoes surgery. Exploratory laparotomy reveals bilateral endometriomas densely adherent to the pelvic sidewalls and total cul de sac obliteration, as well as myomata enlarging the uterus to 10 to 12 weeks size. Total abdominal hysterectomy, bilateral salpingo-oophorectomy is performed. The patient is followed in the hospital for 4-6 days and is discharged home. She receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

Under general anesthesia the abdomen is entered through a midline incision. An exploratory laparotomy is performed. At exploration she is found to have bilateral endometriomas densely adherent to the pelvic sidewalls and total cul de sac obliteration. Total abdominal hysterectomy, bilateral salpingo-oophorectomy is performed. The supporting pedicles containing the tubes, ligaments, and arteries are clamped and cut free. The uterus and cervix are removed along with a narrow rim or cuff of vaginal lining. The vaginal defect is often left open for drainage. The abdominal incision is closed by suturing.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 5 days. The patient is discharged on post op day 5 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 312 Response Rate (%): 72 (23%) Median RVW: 14.325th Percentile RVW: 13.00 75th Percentile RVW: 17.17 Low: 10.50 High: 28.00Median Pre-Service Time: 60 Median Intra-Service Time: 12025th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 169 Low: 60 High: 240

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>---</u>	<u>---</u>
Other Hospital:	<u>70</u>	<u>5</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	58260	Vaginal hysterectomy	11.39
3)	56308	LAVH	13.87
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58150 includes the work of CPT 49000, in addition to the work required to remove the tubes and ovaries. An abdominal hysterectomy requires is more difficult than CPT 58260 or 56308 because the typical patient undergoing the procedure has more anatomic distortion and is more likely to be elderly, have comorbid condition, and to experience post-operative complications.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	120 min. x 0.075		9.00
Same day post	99233	-	1.25
Hospital	99232	-	.88
	99231 x 3	-	1.53
	99238	-	1.06
Office	99213 x 2	-	<u>1.10</u>
			16.33

Note: The work required to perform CPT 58150 for the typical patient in 1995 is undervalued at the level of work RVUs established on the basis of data collected in Phase I of the Harvard study in 1987. According to the National Center for Health Statistics, the overall rate of hysterectomy fell from 43.0 per 10,000 women in 1988 to 39.0 per 10,000 women in 1991. The decline in the hysterectomy rate is primarily due to the availability of other treatments. Therefore, in comparison to the profile of patients undergoing hysterectomy in the mid- to late-1980s, patients have more severe indications for the procedure; women undergoing hysterectomies are those for whom more conservative therapies have failed. More specifically, new surgical techniques and the increasing preference for vaginal surgery have altered the profile of patients undergoing a total abdominal hysterectomy. In particular, the development of the laparoscopic assisted vaginal hysterectomy (LAVH) has allowed many women who would previously undergone an abdominal hysterectomy to have a vaginal hysterectomy. For example, a retrospective review of medical records for 2,563 patients who underwent hysterectomy for benign disease in one large not-for-profit metropolitan hospital found that between January 1991 and December 1993 the proportion of hysterectomies performed abdominally fell from 65% to 36%, while the percentage of hysterectomies performed by LAVH rose from 12% to 45%.

These changes have resulted in an increase in the physician work required to perform CPT 58150. The actual surgical procedure for the typical patient is more technically challenging and the post-operative care frequently more complicated than was the case when the work RVUs for CPT 58150 were established.

In addition, the vignette used in the Harvard Phase I data collection (50-year-old patient with carcinoma in situ of the cervix) does not adequately describe the typical patient undergoing CPT 58150 in 1995 and, in fact did not describe a typical patient for the procedure at that time. Data available from the National Center for Health Statistics indicate that during the period 1985-87, the leading indication for women of all ages undergoing hysterectomy was fibroids. Among Medicare-aged women, a diagnosis of cancer was the indication for surgery for only about one-third of hysterectomy patients. The choice of vignette is significant because the condition described in the vignette does not result in the type of anatomic distortion resulting from fibroids, endometriosis, or chronic infection that is very frequently seen in today's patients and that makes the surgery more difficult.

Public Comments

30-Jun-95

Code: 58150

1995 RVUs: 13

Recommended RVUs: Inc

Ratio:

Long Descriptor: Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

Reference Set (y/n): Y Global Period: 090 Frequency: 27,645 Impact:

Source: 2 Year: 92 Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG

Societies Wishing to Comment: AOA, ASRM 2

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58150	34.7	6.2	14.3	99.6	16.3	0.7	0.3	14.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58150	33421	30489	-4.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58150	96.3	96.8	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58150	general surgery	12.1
	group practices	2
	obstetrics/gynecology	83.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58150	182	5.1	MALIGNANT NEOPLASM OF BODY OF U
	218	5.4	UTERINE LEIOMYOMA
	614	2.1	INFLAMMATORY DISEASE OF OVARY, F

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618	3.2	GENTAL PROLAPSE
621	3.5	DISORDERS OF UTERUS, NOT ELSEWHER
625	2	PAIN AND OTHER SYMPTOMS ASSOCIAT
627	3.2	MENOPAUSAL AND POSTMENOPAUSAL
789	3.1	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58150							
ACOG		090	090	9.26	13.00	1.40	13.00

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58150								
ACOG	13.00	13.00	1.40	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
58150								
ACOG	090	9.26		35		89		47

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58150									
ACOG		1.0		10	4.5		15	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
58150									
ACOG		15		INCR	13.00	xx	n		0.047

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58180 Global Period: 090 Current RVW: 9.06 Recommended RVW: 16.57

CPT Descriptor: Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s) with or without removal of ovary(s)

Source and Summary of Comment to HCFA on this service: ACOG: Requires significantly more mental effort, technical skill, and stress than CPT 49000, but work RVUs for CPT 58180 exceed those for CPT 49000 by an insignificant margin.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52 year old G0 woman has been evaluated for a large pelvic mass. Ultrasound demonstrated bilateral endometriomas densely adherent to the pelvic sidewalls and total cul de sac obliteration, as well as myomata enlarging the uterus to 10 to 12 weeks size. During surgery, excessive bleeding and dense pelvic adhesions make removal of the uterine cervix very difficult. Because the patient is not tolerating her anesthetic very well, a decision is made to perform a supracervical hysterectomy. The patient stabilizes in the recovery room and the remainder of her post-op course is uneventful. She is discharged home on the fourth post-op day. She receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

Under general anesthesia the abdomen is entered through a midline incision. The vascular supply of the uterus is secured in the usual fashion. After the uterine vessels are ligated and tied, the uterine fundus is removed by excision at the level of the internal cervical os. This area is oversewn and hemostasis is achieved. The abdominal incision is closed.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 4 days. The patient is discharged on post op day 4 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 212 Response Rate (%): 55 (26%) Median RVW: 1525th Percentile RVW: 13 75th Percentile RVW: 17 Low: 11 High: 28Median Pre-Service Time: 60 Median Intra-Service Time: 13025th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 150 Low: 20 High: 240

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>30</u>	<u>1</u>
Other Hospital:	<u>60</u>	<u>4</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	58260	Vaginal hysterectomy	11.39
3)	56308	LAVH	13.87
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58180 includes the work of CPT 49000, in addition to the work required to remove the tubes and ovaries. This procedure is more difficult than CPT 58260 or 56308 because the typical patient undergoing the procedure has more anatomic distortion and is more likely to be elderly, have comorbid conditions, and to experience post-operative complications.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	130 min. x 0.075	-	9.75
SD Post	99233	-	1.25
Hospital	99232	-	.88
	99231 x 2	-	1.02
	99238	-	1.06
Office	99213 x 2	-	<u>1.1</u>
			16.57

Public Comments

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Code: 58180

1995 RVUs: 9.06

Recommended RVUs: Inc

Ratio:

Long Descriptor: Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)

Reference Set (y/n): N Global Period: 090 Frequency: 500 Impact:

Source: 2 Year: 92 Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey:

Societies Wishing to Comment: AOA, ASRM 2

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58180	50	21.4	7.1	100	7.1	0	0	15.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58180	512	540	2.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58180	94.3	95.9	0.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58180	general surgery	27.2
	group practices *	2.6
	obstetrics/gynecology	67.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58180	153	1.8	MALIGNANT NEOPLASM OF COLON
	183	7.1	MALIGNANT NEOPLASM OF OVARY AND
	218	3.6	UTERINE LEIOMYOMA

Public Comments

30-Jun-95

220	1.8	BENIGN NEOPLASM OF OVARY
223	1.8	BENIGN NEOPLASM OF KIDNEY AND OT
236	1.8	NEOPLASM OF UNCERTAIN BEHAVIOR O
614	3.6	INFLAMMATORY DISEASE OF OVARY, F
789	7.1	OTHER SYMPTOMS INVOLVING ABDOM

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58180							
ACOG		090	090	8.49	9.06	1.07	9.06

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58180								
ACOG	9.06	9.06	1.07	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58180								
ACOG	090	8.49		30	*	71		42

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58180									
ACOG	*	1.0	*	10	4.0	*	14	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58180									
ACOG	*	15		INCR	9.06	ob	3		0.055

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58210 Global Period: 090 Current RVW: 23.97 Recommended RVW: 28.23

CPT Descriptor: Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and periaortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)

Source and Summary of Comment to HCFA on this service: ACOG: Requires total physician work approximately equivalent to the work for CPT 55845, but has lower work RVUs.

SGO: Undervalued in comparison to CPT 58150 -- difference in work RVUs does not reflect the actual difference in physician work.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old has been evaluated for a cervical lesion approximately 2 cm in largest diameter which is confined to the cervix. A biopsy revealed a well-differentiated squamous cell cancer. She now undergoes a radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and selected periaortic lymph node sampling. After hospital discharge she receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Operative Service:

The patient is examined under anesthesia to assess operability. An incision is made and carried by layers until the peritoneal cavity is entered. An exploration of the abdominal and pelvic cavities is performed. The lymph nodes are sent for frozen section. If without evidence of metastases, the uterus, parametria, cervix and upper 1/3 of the vagina are removed by dissecting the ureter from the parametria and tunnel and by cutting, clamping and suturing vascular and supporting pedicles. A radical bilateral pelvic lymphadenectomy is performed either prior to or immediately following the radical hysterectomy. The pelvic lymphadenectomy skeletonizes the common external, hypogastric and obturator vessels. Closed suction drains may be used. The abdomen is closed in layers and dressing applied.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 7 days. The patient is discharged on post op day 7 with instructions for follow-up care. The patient is reevaluated three times post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 112 Response Rate (%): 53 (47%) Median RVW: 27.525th Percentile RVW: 19 75th Percentile RVW: 28.5 Low: 16.3 High: 60.5Median Pre-Service Time: 75 Median Intra-Service Time: 24025th Percentile Intra-Svc Time: 202 75th Percentile Intra-Svc Time: 300 Low: 90 High: 340Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 45ICU: 25 1Other Hospital: 100 6Office: 45 3**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	38770	Pelvic lymphadenectomy	12.10
2)	58260	Vaginal hysterectomy	11.39
3)	55845	Prostatectomy with bilateral lymphadenectomy	26.73
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The total physician work required to perform CPT 58210 is equivalent to work associated with CPT 55845. Mental effort, technical skill and stress are similar for the radical abdominal hysterectomy and the retroperitoneal radical prostatectomy, although CPT 58210 also requires a para-aortic lymph node dissection.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215 = 1.51 + 99211 = .17 >		1.68
Intra-service	240 minutes x .075	-	18.00
Day of procedure	99233	-	1.25
ICU	99233	-	1.25
Hospital visits	99232 x 2	-	1.76
	99231 x 3	-	1.53
	99238	-	1.06
Office visits	99214	-	.94
	99212 x 2	-	<u>.76</u>
			28.23

Public Comments

30-Jun-95

Code: 58210

1995 RVUs: 23.97

Recommended RVUs: 28.00

Ratio:

Long Descriptor: Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)

Reference Set (y/n): N Global Period: 090 Frequency: 1,618 Impact: 6521

Source: 4 Year: 93 Public Comment Letter: 335

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment: AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58210	32.9	10.5	7.9	100	2.6	0	0	7.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58210	1602	1802	6.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58210	96.4	96.7	0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58210	general surgery	16.8
	group practices	2.5
	obstetrics/gynecology	78.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58210	180	2.6	MALIGNANT NEOPLASM OF CERVIX UTE
	182	19.7	MALIGNANT NEOPLASM OF BODY OF U
	183	2	MALIGNANT NEOPLASM OF OVARY AND

Public Comments

30-Jun-95

553	1.3	OTHER HERNIA OF ABDOMINAL CAVITY
V10	1.3	PERSONAL HISTORY OF MALIGNANT NE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58210							
ACOG		090	090	18.18	23.97	1.32	23.97
SGO		090	090	18.18	23.97	1.32	23.97

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58210								
ACOG	23.97	23.97	1.32	1.00	1.00	1.00	INCR	310
SGO	23.97	23.97	1.32	1.00	1.00	1.00	28.00	335

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58210								
ACOG	090	18.18		39		192		62
SGO	090	18.18		39		192		62

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58210									
ACOG		1.0		15	8.5		15	2.0	3.5
SGO		1.0		15	8.5		15	2.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58210									
ACOG		15		INCR	23.97	ob	3		0.041
SGO		15		28.00	23.97	ob	3		0.041

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58240 Global Period: 090 Current RVW: 28.79 Recommended RVW: 41.20

CPT Descriptor: Pelvic exenteration, for gynecologic malignancy with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and transplantations, and or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof.

Source and Summary of Comment to HCFA on this service: ACOG and SGO: Undervalued in comparison to CPT 51597 -- procedures are identical, but 58240 has much lower work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38 year old patient was treated with radiation therapy for a stage IB squamous cell cervical carcinoma. She has been evaluated for a central recurrence 2 years following therapy. A biopsy of the lesion was consistent with the primary tumor. She undergoes a pelvic exenteration with total abdominal hysterectomy, removal of bladder and ureteral reimplantation and resection of rectum and creation of colostomy. Following hospital discharge, she receives office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Operative Services:

An incision is made and carried by layers until the peritoneal cavity is entered. An exploration of the abdominal and pelvic cavities is performed. The bowel is packed into the upper abdomen. If there is no evidence of metastatic disease, the disease is free of the pelvic sidewalls, the procedure is begun. The uterus, cervix, parametria, all or part of the vagina, bladder and rectosigmoid are removed. An end sigmoid colostomy or colonic reanastomosis is performed. The procedure requires an abdominal and vaginal approach. Drains may be placed. A catheter drains the conduit and ureteral stents are usually placed. The abdomen is closed in layers and dressings applied.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 16 days. The patient is discharged on post op day 16 with instructions for follow-up care. The patient is reevaluated six times post operatively.

SURVEY DATA:

Specialty: ACOG

Sample Size: 112 Response Rate (%): 54 (48%) Median RVW: 35

25th Percentile RVW: 26 75th Percentile RVW: 45 Low: 11 High: 121.52

Median Pre-Service Time: 120 Median Intra-Service Time: 480

25th Percentile Intra-Svc Time: 360 75th Percentile Intra-Svc Time: 600 Low: 300 High: 720

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>75</u>	
ICU:	<u>90</u>	<u>4</u>
Other Hospital:	<u>222</u>	<u>12</u>
Office:	<u>90</u>	<u>6</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	51597	Pelvic exenteration, urinary system	35.27
2)	44140	Partial colectomy with anastomosis	16.97
3)	44141	Partial colectomy with cecostomy	17.36
4)	38770	Pelvic lymphadenectomy	12.10

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58240 is identical to CPT 51597.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	465 x .05	-	23.25
Day of	99233	-	1.25
ICU	99232 x 4	-	3.52
Hospital	99232 x 4	-	3.52
	99231 x 7	-	3.57
	99238	-	1.06
Office	99214	-	.94
	99213 x 4	-	2.20
	99212	-	<u>.38</u>
			41.20

CMD Comments

30-Jun-95

Code: 58240

1995 RVUs: 28.79

Recommended RVUs: 32.25

Ratio: 0.12

Long Descriptor: Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 264 **Impact:** 913.44

Source: 4 **Year:** 93 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
58240			
	51596 REMOVE BLADDER, CREATE POUCH	36.27	090

CMD Comment:

The large difference between this code and 51597 (pelvic exenteration, male) is due to a difference of over two hours in estimated intraservice time in the Harvard study. There is probably very little real difference in work, so the most practical step would be to average the codes and assign the same RVU to both.

Societies Wishing to Survey: ACOG

Societies Wishing to Comment: AOA, ASCRS, AUA

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58240	62.5	0	0	100	0	0	0	0

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
58240	315	292	-3.8

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58240	98.4	97.9	-0.2

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
58240		
	general surgery	37.3
	group practices	2.7
	obstetrics/gynecology	47.7
	urology	5.5

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

ICD9	Pct of Time Used	ICD9 Descriptor
58240		
154	3.1	MALIGNANT NEOPLASM OF RECTUM, RE
180	3.1	MALIGNANT NEOPLASM OF CERVIX UTE
183	6.3	MALIGNANT NEOPLASM OF OVARY AND
184	9.4	MALIGNANT NEOPLASM OF OTHER AND
560	3.1	INTESTINAL OBSTRUCTION WITHOUT M
593	3.1	OTHER DISORDERS OF KIDNEY AND UR
878	3.1	OPEN WOUND OF GENITAL ORGANS (EX

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58240							
ACOG		090	090	26.50	28.79	1.09	28.79
CMD		090	090	26.50	28.79	1.09	28.79
SGO		090	090	26.50	28.79	1.09	28.79

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58240								
ACOG	28.79	28.79	1.09	1.00	1.00	1.00	35.27	310
CMD	28.79	28.79	1.09	1.00	1.00	1.00	32.25	
SGO	28.79	28.79	1.09	1.00	1.00	1.00	35.27	335

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Htime	Notett	Imppt
58240								
ACOG	090	26.50		46		300		73
CMD	090	26.50		46		300		73
SGO	090	26.50		46		300		73

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58240									
ACOG		1.0		15	10.0		20	3.0	4.0
CMD		1.0		15	10.0		20	3.0	4.0
SGO		1.0		15	10.0		20	3.0	4.0

Harvard Data:

CMD Comments

30-Jun-95

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
58240									
ACOG		20		35.27	28.79	ob	3		0.043
CMD		20		32.25	28.79	ob	3		0.043
SGO		20		35.27	28.79	ob	3		0.043

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58301 Global Period: 0 Current RVW: .73 Recommended RVW: 1.5

CPT Descriptor: Removal of intrauterine device

Source and Summary of Comment to HCFA on this service: ACOG: Undervalued in comparison to CPT 42809 - requires greater technical skill, though somewhat less stress. Pre- and post-service work is similar.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32 year old G1P1 woman requests the removal of her IUD for a planned pregnancy. The string cannot be located in the cervix during an office evaluation. Under aseptic conditions, the cervix is gently dilated sufficient to permit the introduction of a uterine forceps which is used to successfully grasp and remove the IUD.

Description of Pre-Service Work:

Informed consent is obtained and the procedure is explained to the patient.

Intra-Service Work:

A pelvic examination is performed. A single toothed tenaculum is applied to the anterior lip of the cervix. The strings of the IUD are grasped and the IUD is removed.

Description of Post-Service Work:

The patient is observed for possible reaction to the procedure and then given instructions regarding the consequences of unprotected sexual activity.

SURVEY DATA:

Specialty: ACOG

Sample Size: 100 Response Rate (%): 33 (33%) Median RVW: 1.5

25th Percentile RVW: 1.14 75th Percentile RVW: 2.27 Low: .42 High: 3.8

Median Pre-Service Time: 15 Median Intra-Service Time: 15

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 20 Low: 5 High: 30

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 10

ICU: ----

Other Hospital:	----	----
Office:	<u>15</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99215	Level 5 established patient office visit	1.51
2)			
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Total work is equivalent for CPT 58301 and 99215. Time is similar for both procedures, but CPT 58301 entails the risk of infection and uterine perforation. The survey median seems reasonable.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Public Comments

30-Jun-95

Code: 58301

1995 RVUs: 0.73

Recommended RVUs: Inc

Ratio:

Long Descriptor: Removal of intrauterine device (IUD)

Reference Set (y/n): N

Global Period: 000

Frequency: 163

Impact:

Source: 2

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ACEP, AOA, ASRM 2

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58301	0	0	0	100	66.7	0	0	33.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58301	111	174	25.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58301	9	8	-0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58301	general/family practice	9.2
	group practices	4.6
	internal medicine	4.6
	obstetrics/gynecology	80.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58301	616	8.3	INFLAMMATORY DISEASE OF CERVIX, V
	627	16.7	MENOPAUSAL AND POSTMENOPAUSAL
	996	8.3	COMPLICATIONS PECULIAR TO CERTAI

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58301							
ACOG		000	000	0.48	0.73	1.52	0.73

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58301								
ACOG	0.73	0.73	1.52	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58301								
ACOG	000	0.48						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58301									
ACOG									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58301									
ACOG				INCR	0.73	ob	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58410 Global Period: 090 Current RVW: 6.78 Recommended RVW: 12.31

CPT Descriptor: Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure); with presacral sympathectomy

Source and Summary of Comment to HCFA on this service: ACOG: Requires physician work at least equivalent to that associated with CPT 49000, but has fewer work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26 year old female patient has been evaluated for chronic, severe central pelvic pain. On physical examination she has a retro-displaced uterus. Previous laparoscopic examination has documented endometriosis. She has failed all conservative methods of pain management. She wishes to conserve her reproductive capacities. She undergoes a uterine suspension and presacral sympathectomy. Her post operative course is uncomplicated and she is discharged home on the third post operative day. She is seen for 3 and 6 weeks post operative evaluations and reports significantly less pain.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

Under general anesthesia the abdomen is entered through a low abdominal transverse incision. The bowel contents are packed away. The sigmoid colon is mobilized to expose the peritoneum overlying the sacrum. The retroperitoneal space is entered and the sympathetic nerve supply to the pelvis is isolated. The appropriate nerve bundle bilaterally is ligated and divided (Pre-sacral sympathectomy). The uterine suspension is performed in a variety of ways. Commonly, the round ligaments are shortened by "gathering" the ligaments bilaterally with a running suture. Alternatively, the uterus may be suspended by suturing the round ligaments or other appendage to the anterior abdominal peritoneum or fascia. The abdominal incision is closed and the patient is taken to the recovery room.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 100 Response Rate (%): 22 (22%) Median RVW: 1225th Percentile RVW: 9.5 75th Percentile RVW: 13.2 Low: 9 High: 15Median Pre-Service Time: 60 Median Intra-Service Time: 11025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 120 Low: 60 High: 180

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>60</u>	<u>3</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	57282	Sacrospinous ligament fixation	8.06
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58410 is approximately equivalent to one and one-half times the work of CPT 49000 or CPT 57282. The work required to perform the uterine suspension is approximately equivalent to the work of CPT 57272. The additional work required for the presacral sympathectomy is approximately half the work of CPT 57272.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	100 min. x .06	-	6.0
Same day	99233	-	1.25
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99213 x 2	-	<u>1.1</u>
			12.31

Public Comments

30-Jun-95

Code: 58410

1995 RVUs: 6.78

Recommended RVUs: Inc

Ratio:

Long Descriptor: Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; with presacral sympathectomy

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 8 **Impact:**

Source: 1 **Year:** 92 **Public Comment Letter:** 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ASRM 2

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58410	16	10	-20.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58410	75	40	-17.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58410	obstetrics/gynecology	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58410	ACOG	090	090	7.92	6.78	0.86	6.78

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58410								
ACOG	6.78	6.78	0.86	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58410								
ACOG	090	7.92		31	*	91		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58410									
ACOG	*	1.0	*	10	4.0	*	15	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58410									
ACOG	*	15		INCR	6.78	ob	3		0.035

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58520 Global Period: 090 Current RVW: 6.35 Recommended RVW: 11.11

CPT Descriptor: Hysterorrhaphy, repair of ruptured uterus (non-obstetrical)

Source and Summary of Comment to HCFA on this service: ACOG: Requires physician work at least equivalent to that associated with CPT 49000, but has fewer work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30 year old nulliparous woman on no hormone replacement is evaluated for abnormal glandular cells on Pap smear. At conization a severely stenotic internal os is identified. While attempting to enter the endometrial cavity for D&C the uterus is perforated and brisk bleeding ensues. A laparotomy incision is made and the uterine defect is identified and closed in layers after the internal os is dilated from above and endometrial sampling obtained. After hospital discharge, she receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work was conducted during the original procedure. Informed consent had already been obtained for possible complications of the original procedure.

Description of Intra-Service Work:

A laparotomy incision is made and the uterine tear is identified and closed in layers after the internal OS is dilated from above and endometrial sampling obtained.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 4 days. The patient is discharged on post op day 4 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:

Specialty: ACOG

Sample Size: 100 Response Rate (%): 36 (36%) Median RVW: 12

25th Percentile RVW: 10 75th Percentile RVW: 87 Low: 9.5 High: 17

Median Pre-Service Time: 40 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 62 75th Percentile Intra-Svc Time: 120 Low: 50 High: 120

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>50</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>60</u>	<u>4</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	51860	Cystorrhaphy - simple	11.17
2)	51865	Cystorrhaphy - complicated	13.99
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58520 is comparable in time, mental effort, technical skill and stress to CPT 51860 and somewhat less work than CPT 51965. The survey median seems slightly high.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	80 min. x .06	-	4.8
Day of service	99233	-	1.25
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99213 x 2	-	<u>1.1</u>
			11.11

Public Comments

30-Jun-95

Code: 58520

1995 RVUs: 6.35

Recommended RVUs: Inc

Ratio:

Long Descriptor: Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)

Reference Set (y/n): N

Global Period: 090

Frequency: 13

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ASRM 2

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58520	25	14	-25.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58520	40	100	30

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58520	general surgery	42.9
	obstetrics/gynecology	42.9
	vascular surgery	14.3

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58520							
	ACOG	090	090	7.27	6.35	0.87	6.35

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58520								
ACOG	6.35	6.35	0.87	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58520								
ACOG	090	7.27		28	*	58		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58520									
ACOG	*	1.0	*	10	3.0	*	15	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58520									
ACOG	*	15		INCR	6.35	ob	3		0.057

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58540 Global Period: 090 Current RVW: 8.58 Recommended RVW: 13.96

CPT Descriptor: Hysteroplasty, repair of uterine anomaly (Strassman type)

Source and Summary of Comment to HCFA on this service: ACOG: Requires greater time, mental effort, technical skill, and stress than CPT 49000, but has fewer work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26 year old female G5 P0 Sab5 has been referred for repair of congenital uterine anomaly as a cause of her repetitive spontaneous pregnancy losses. Hormonal evaluation showed normal luteal phase progesterone, euprolactinemia, and normal thyroid function. Further evaluations revealed the couple to have normal karyotypes, and the female spouse to be free of either infectious or systemic diseases. Hysterosalpingogram and laparoscopy revealed a bicornuate uterus. An exploratory laparotomy is performed. The bicornuate uterus is repaired by making a transverse incision along the superior aspect of the uterine fundus down to the endometrial cavity. Unification of the bi-valved uterus is accomplished by closing the incision along the anterior-posterior axis of the uterus. The myometrial defect is closed in multiple layers and meticulous hemostasis obtained. The serosa is closed with fine suture to try to decrease the risk of post-operative adhesion formation. The abdominal wall is closed in a routine fashion. After hospital discharge, she receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

An exploratory laparotomy is performed. The bicornuate uterus is repaired by making a transverse incision along the superior aspect of the uterine fundus down to the endometrial cavity. Unification of the bi-valved uterus is accomplished by closing the incision along the anterior-posterior axis of the uterus. The myometrial defect is closed in multiple layers and meticulous hemostasis obtained. The serosa is closed with fine suture to try to decrease the risk of post-operative adhesion formation. The abdominal wall is closed in a routine fashion.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:

Specialty: ACOG

Sample Size: 100 Response Rate (%): 33 (33%) Median RVW: 14

25th Percentile RVW: 11.97 75th Percentile RVW: 16.81 Low: 9 High: 18.77

Median Pre-Service Time: 60 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 82 75th Percentile Intra-Svc Time: 150 Low: 60 High: 180

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>50</u>	<u>3</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	59515	Cesarean delivery including postpartum care	16.55
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58540 requires slightly less total work than CPT 59515. While 58540 demands more intra-service time than CPT 59515, the cesarean delivery typically includes substantial physician work managing labor.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	102 min. x .075	-	7.65
Day of service	99233	-	1.25
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99213 x 2	-	<u>1.1</u>
			13.96

Public Comments

30-Jun-95

Code: 58540

1995 RVUs: 8.58

Recommended RVUs: Inc

Ratio:

Long Descriptor: Hysteroplasty, repair of uterine anomaly (Strassman type)

Reference Set (y/n): N

Global Period: 090

Frequency: 4

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
58540	12	2	-59.2

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58540	75	100	12.5

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
58540	obstetrics/gynecology	100

Claims-Level Diagnosis Information:

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58540	ACOG		090	090	8.75	8.58	0.98	8.58

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58540								
ACOG	8.58	8.58	0.98	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Htime	Notett	Imppt
58540								
ACOG	090	8.75		33	*	91		42

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58540									
ACOG	*	1.0	*	10	3.5	*	15	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58540									
ACOG	*	15		INCR	8.58	ob	3		0.047

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58750 Global Period: 090 Current RVW: 8.82 Recommended RVW: 15.14

CPT Descriptor: Tubotubal anastomosis

Source and Summary of Comment to HCFA on this service: ACOG: Requires significantly greater time, mental effort, technical skill, and stress than CPT 49000, but has approximately the same RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old gravida 2 para 2 remarried woman desires fertility post tubal ligation. Laparoscopic evaluation showed 4 cm tube distally on right, 3 cm tube proximally on right. The patient had previously undergone a left salpingectomy. There is no other pelvic pathology. She now undergoes tubotubal anastomosis. Operating loops are used for magnification. Microsurgical instruments and suture are used. Chromotubation demonstrates patency following the procedure. After hospital discharge, she receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

Under appropriate anesthesia, an abdominal incision is made and an exploratory laparotomy performed. The uterus and tubal segments are elevated with appropriate packing and adhesions are lysed as indicated. The segments are mobilized, with attention to maintain hemostasis but retaining blood supply. The blocked portion of the tube is excised and it is sutured cleanly to the unblocked portion. This is done through the use of an operating microscope to obtain micro cautery hemostasis. Patency of the segments is established. The packs are removed and the abdomen closed.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOG and ASRMSample Size: 150 Response Rate (%): 43 (29%) Median RVW: 14.2625th Percentile RVW: 12.31 75th Percentile RVW: 17.75 Low: 7 High: 29Median Pre-Service Time: 60 Median Intra-Service Time: 12025th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 180 Low: 55 High: 300

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>40</u>	<u>3</u>
Office:	<u>20</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	55400	Vaso vasostomy	8.25
3)	54901	Epididymovasostomy - bilateral	17.30
4)	54900	Epididymovasostomy - unilateral	12.61

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58750 requires work midway between CPT 54901 and 54900.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	120 min. x .075	-	9
Day of Service	99233	-	1.25
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99212	-	.38
	99213	-	<u>.55</u>
			15.14

Public Comments

30-Jun-95

Code: 58750

1995 RVUs: 8.82

Recommended RVUs: Inc

Ratio:

Long Descriptor: Tubotubal anastomosis

Reference Set (y/n): N

Global Period: 090

Frequency: 31

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58750	50	0	0	50	50	0	0	0

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
58750	20	42	44.9

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58750	95	90.5	-2.3

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
58750	general surgery	9.5
	group practices	4.8
	internal medicine	4.8
	obstetrics/gynecology	81

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58750	281	12.5	OTHER DEFICIENCY ANEMIAS
	401	12.5	ESSENTIAL HYPERTENSION
	628	25	INFERTILITY, FEMALE

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58750							
ACOG		090	090	9.09	8.82	0.97	8.82

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58750								
ACOG	8.82	8.82	0.97	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58750								
ACOG	090	9.09		35		119		44

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58750									
ACOG		1.0	*	10	3.5		15	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
58750									
ACOG		15		INCR	8.82	ob	3		0.034

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58752 Global Period: 090 Current RVW: 7.94 Recommended RVW: 15.14

CPT Descriptor: Tubouterine implantation

Source and Summary of Comment to HCFA on this service: ACOG: Requires significantly greater time, mental effort, technical skill, and stress than CPT 49000, but has fewer RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old gravida 2 para 2 remarried woman desires fertility post tubal ligation. Laparoscopic evaluation showed 6 cm tube distally and no proximal tube on the right. The left tube was previously removed. There is no other pelvic pathology. She now undergoes tubouterine implantation. The proximal portion of the tube is opened and implanted into the tunnel created in the uterine cornua. Tubal patency is established by chromotubation. After hospital discharge, the patient receives routine office follow-up during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

Under appropriate anesthesia, an abdominal incision is made, retractor placed, uterus and tubal segments elevated with appropriate packing, adhesions lysed as indicated. The distal segment is mobilized. The uterine cornu is incised until patency is established. The tubal lumen is approximated via repair of mesosalpinx. The ligated portion of distal tubal segment is excised. The tubal muscularis is approximated with 8-0 sutures. Patency is established, the packs are removed and the abdomen is closed.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOG and ASRMSample Size: 150 Response Rate (%): 39 (26%) Median RVW: 14.525th Percentile RVW: 12.5 75th Percentile RVW: 17.75 Low: 8 High: 30Median Pre-Service Time: 60 Median Intra-Service Time: 15025th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 160 Low: 75 High: 360

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>40</u>	<u>3</u>
Office:	<u>20</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	55400	Vasovasostomy	8.25
3)	54901	Epididymovasostomy - bilateral	17.30
4)	54900	Epididymovasostomy - unilateral	12.61

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58752 requires work midway between CPT 54901 and 54900.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	120 min. x .075	-	9
Day of service	99233	-	1.25
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99212	-	.38
	99213	-	<u>.55</u>
			15.14

Public Comments

30-Jun-95

Code: 58752

1995 RVUs: 7.94

Recommended RVUs: Inc

Ratio:

Long Descriptor: Tubouterine implantation

Reference Set (y/n): N

Global Period: 090

Frequency: 2

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58752	3	4	15.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58752	0	50	25

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58752	obstetrics/gynecology	50
	other nonphysician prov	50

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58752							
	ACOG	090	090	10.30	7.94	0.77	7.94

Public Comments

30-Jun-95

Harvard Data:

Comm	Mawk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58752								
ACOG	7.94	7.94	0.77	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
58752								
ACOG	090	10.30		37	*	139		44

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58752									
ACOG	*	1.0	*	10	4.5	*	15	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
58752									
ACOG	*	15		INCR	7.94	ob	3		0.035

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58760 Global Period: 090 Current RVW: 7.16 Recommended RVW: 12.86

CPT Descriptor: Fimbrioplasty

Source and Summary of Comment to HCFA on this service: ACOG: Requires significantly greater time, mental effort, technical skill, and stress than CPT 49000, but has fewer RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old gravida 0010 married woman desires fertility. She is status post left salpingectomy for ectopic pregnancy, age 30, and was noted to have right fimbrial agglutination at that time. She now undergoes fimbrioplasty. Microsurgical instruments and sutures, as well as operating loops for magnification are used. After hospital discharge, the patient receives routine office follow-up during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

Under appropriate anesthesia, an abdominal incision is made, retractor placed, uterus and tub elevated with appropriate packing, adhesions lysed as indicated. The tube is mobilized, dye injected. Areas of fimbrial agglutination are carefully lysed to allow maximal motion of fimbrial segments. Patency established. Packs removed. Abdomen closed.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice.

SURVEY DATA:Specialty: ACOG and ASRMSample Size: 150 Response Rate (%): 38 (25%) Median RVW: 12.525th Percentile RVW: 11 75th Percentile RVW: 15.73 Low: 9 High: 25Median Pre-Service Time: 60 Median Intra-Service Time: 12025th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 150 Low: 50 High: 210

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>43</u>	<u>3</u>
Office:	<u>25</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	44005	Freeing of bowel adhesions	12.52
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58760 requires work approximately equivalent to CPT 44005.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	112 min. x .06	-	6.72
Day of service	99233	-	1.25
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99213	-	.55
	99212	-	<u>.38</u>
			12.86

Public Comments

30-Jun-95

Code: 58760

1995 RVUs: 7.16

Recommended RVUs: Inc

Ratio:

Long Descriptor: Fimbrioplasty

Reference Set (y/n): N

Global Period: 090

Frequency: 6

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58760	10	10	0

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58760	50	80	15

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58760	obstetrics/gynecology	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58760							
	ACOG	090	090	7.79	7.16	0.92	7.16

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58760								
ACOG	7.16	7.16	0.92	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
58760								
ACOG	090	7.79		32		88		41

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58760									
ACOG		1.0	*	10	3.0		15	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58760									
ACOG		15		INCR	7.16	ob	3		0.038

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58770 Global Period: 090 Current RVW: 6.96 Recommended RVW: 13.34

CPT Descriptor: Salpingostomy (neosalpingostomy)

Source and Summary of Comment to HCFA on this service: ACOG: Requires significantly greater mental effort, technical skill, and stress than CPT 49000, but has fewer RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old gravida 0010 married woman desires fertility. At age 30 she underwent left salpingectomy for an ectopic pregnancy and was noted to have right hydrosalpinx at that time. You now perform salpingostomy. Microsurgical instruments and sutures, as well as operating loops for magnification are used. After hospital discharge, the patient receives routine office follow-up during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

Under appropriate anesthesia, an abdominal incision is made, retractor placed, uterus and tube elevated with appropriate packing, adhesions lysed as indicated. The tube is mobilized, dye injected. Area of tubal occlusion identified. Stellate incision made. Hemostasis obtained. Leaflets inverted, sutured to serosa with 6-0 sutures. Patency established. Packs removed. Abdomen closed.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOG and ASRMSample Size: 150 Response Rate (%): 37 (25%) Median RVW: 13.4525th Percentile RVW: 11.05 75th Percentile RVW: 15.25 Low: 9.20 High: 30Median Pre-Service Time: 60 Median Intra-Service Time: 12025th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 150 Low: 60 High: 210

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>45</u>	<u>3</u>
Office:	<u>25</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	44005	Freeing of bowel adhesions	12.52
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 58770 requires total physician work slightly greater in technical skill than that associated with CPT 44005.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	120 min. x .06	-	7.2
Day of service	99233	-	1.25
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99213	-	.55
	99212	-	<u>.38</u>
			13.34

Public Comments

30-Jun-95

Code: 58770

1995 RVUs: 6.96

Recommended RVUs: Inc

Ratio:

Long Descriptor: Salpingostomy (salpingoneostomy)

Reference Set (y/n): N

Global Period: 090

Frequency: 36

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58770

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
58770	29	34	8.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58770	75.9	82.4	3.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
58770	cardiac surgery	5.9
	general/family practice	5.9
	group practices	5.9
	obstetrics/gynecology	82.4

Claims-Level Diagnosis Information:

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58770							
ACOG		090	090	7.34	6.96	0.95	6.96

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58770								
ACOG	6.96	6.96	0.95	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58770								
ACOG	090	7.34		30	*	78		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58770									
ACOG	*	1.0	*	10	3.0	*	15	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58770									
ACOG	*	15		INCR	6.96	ob	3		0.041

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58822 Global Period: 090 Current RVW: 6.18 Recommended RVW: 12.22

CPT Descriptor: Drainage of ovarian abscess; abdominal approach

Source and Summary of Comment to HCFA on this service: ACOG: Requires approximately equivalent intra-service time, but more mental effort, technical skill and stress than CPT 49000. In addition, post-operative work is likely to exceed that for CPT 49000, but CPT 58822 has fewer work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 19 year old female has been admitted to the hospital with severe pelvic pain and high fever. Workup and evaluation revealed the presence of a large right tubo-ovarian abscess following appendectomy. Despite aggressive antibiotic therapy the patient has remained febrile with little or no clinical improvement. A decision is made to drain the abscesses surgically. The patient wishes to conserve her reproductive capacities. The patient undergoes abdominal drainage of the abscesses. At surgery multiple adhesions are released, necrotic tissue debrided, and copious irrigation used. After 5 additional days of antibiotic therapy post operatively, she becomes afebrile and is discharged home. She is seen for a six weeks post-op evaluation and is doing well.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

Under general anesthesia the abdomen is entered through a midline or low transverse incision. The bowel contents are packed away and the pelvis and abdomen are explored. The abscess is localized, incised, and drained. Copious lavage is used. An intra-operative decision is made as to which organs can be preserved. Numerous drains are placed in the area of the abscess and brought out through separate small abdominal incisions. The abdomen is closed and the patient is taken to the recovery room.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 6 days. The patient is discharged on post op day 6 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 100 Response Rate (%): 35 (35%) Median RVW: 1225th Percentile RVW: 11 75th Percentile RVW: 15 Low: 8.99 High: 20Median Pre-Service Time: 60 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 120 Low: 55 High: 180

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>80</u>	<u>6</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	49020	Drainage peritoneal abscess	9.06
3)	49060	Drainage retro peritoneal abscess	10.55
4)	44900	I & D appendiceal abscess	7.86

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The technical skill and stress associated with CPT 58822 are greater for CPT 49060 because of the risk of impairing future fertility.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	90 min. x .06	-	5.4
Day of service	99233	-	1.25
Hospital	99232	-	.88
	99231 x 2	-	1.02
	99238	-	1.06
Office	99213 x 2	-	<u>1.1</u>
			12.22

Public Comments

30-Jun-95

Code: 58822

1995 RVUs: 6.18

Recommended RVUs: Inc

Ratio:

Long Descriptor: Drainage of ovarian abscess; abdominal approach

Reference Set (y/n): N

Global Period: 090

Frequency: 22

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ASRM 2

Trends Analysis - Beneficiary Information:

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
58822	25	18	-15.1

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58822	80	77.8	-1.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
58822	general surgery	44.4
	obstetrics/gynecology	33.3
	radiology	11.1
	thoracic surgery	11.1

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58822							

Public Comments

30-Jun-95

ACOG	090	090	6.03	6.18	1.02	6.18
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58822								
ACOG	6.18	6.18	1.02	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58822								
ACOG	090	6.03		26	*	64		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58822									
ACOG	*	0.5	*	10	1.5	*	15	0.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58822									
ACOG	*	15		INCR	6.18	ob	3		0.048

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58952 Global Period: 090 Current RVW: 21.35 Recommended RVW: 23.08

CPT Descriptor: Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking

Source and Summary of Comment to HCFA on this service: ACOG: Requires greater time, mental effort, and technical skill than CPT 49215, but has approximately the same work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59 year old woman presented with ascites and a pelvic mass. Evaluation has yielded a presumed diagnosis of ovarian cancer. She now undergoes a resection of ovarian malignancy with radical dissection, which includes a bilateral salpingo-oophorectomy, omentectomy and removal of pelvic tumor and abdominal tumor. Following hospital discharge, she receives follow-up office care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Operative Work:

An incision is made and carefully carried by layers until the peritoneal cavity is entered. Cytologic washings and subdiaphragmatic scrapings are taken. The abdomen and pelvis are explored and the extent of tumor assessed. A bilateral salpingo-oophorectomy is performed by dissecting the pelvic sidewalls, ureters, and sigmoid from the adnexal masses. The pelvic peritoneum may need to be removed as part of the radical resection. An omentectomy is performed. An attempt is made to remove all tumor nodules larger than 1 cm in the abdomen and pelvis. An omentectomy is performed. The abdomen is closed in layers and the dressing applied.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 9 days. The patient is discharged on post op day 9 with instructions for follow-up care. The patient is reevaluated three times post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 112 Response Rate (%): 55 (49%) Median RVW: 23.3525th Percentile RVW: 18 75th Percentile RVW: 30 Low: 13 High: 48.40Median Pre-Service Time: 60 Median Intra-Service Time: 24025th Percentile Intra-Svc Time: 180 75th Percentile Intra-Svc Time: 270 Low: 120 High: 320

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>60</u>	
ICU:	<u>45</u>	<u>2</u>
Other Hospital:	<u>105</u>	<u>7</u>
Office:	<u>45</u>	<u>3</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49215	Excision presacral tumor	21.05
2)	44140	Partial colectomy	16.97
3)	49000	Exploratory laparotomy	8.99
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Intra-service work for CPT 58952 requires a higher level of time, mental effort, and technical skill/physical effort because CPT 49215 involves only the removal of a single tumor, while CPT 58952 includes upper abdominal tumor debulking as well. Post-service work for CPT 58952 is greater than post-service work for CPT 49215 due to greater blood loss and higher risk of infection.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	240 x .05	-	12.00
Day of procedure	99233	-	1.25
ICU	99232 x 2	-	1.76
Hospital	99232 x 2	-	1.76
	99231 x 4	-	2.04
	99238	-	1.06
Office	99214	-	.94
	99212 x 2	-	<u>.76</u>
			23.08

Public Comments

30-Jun-95

Code: 58952

1995 RVUs: 21.35

Recommended RVUs: 33.00

Ratio:

Long Descriptor: Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy, with radical dissection for debulking

Reference Set (y/n): N Global Period: 090 Frequency: 1,551 Impact: 18069

Source: 4 Year: 93 Public Comment Letter: 335

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58952	36.5	7.1	4.7	100	7.1	0	0	5.1

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
58952	1398	1720	10.9

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58952	96.5	98.9	1.2

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
58952	general surgery	23.7
	group practices	4.1
	obstetrics/gynecology	69.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58952	182	1.2	MALIGNANT NEOPLASM OF BODY OF U
	183	18.6	MALIGNANT NEOPLASM OF OVARY AND
	620	1.2	NONINFLAMMATORY DISORDERS OF OV

Public Comments

30-Jun-95

789	2.3	OTHER SYMPTOMS INVOLVING ABDOM
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfewk95	Ratio5h	Mfewk92
58952							
ACOG		090	090	16.46	21.35	1.30	21.35
SGO		090	090	16.46	21.35	1.30	21.35

Harvard Data:

Comm	Mswk93	Mfewk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58952								
ACOG	21.35	21.35	1.30	1.00	1.00	1.00	INCR	310
SGO	21.35	21.35	1.30	1.00	1.00	1.00	33.00	335

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58952								
ACOG	090	16.46		43		199		55
SGO	090	16.46		43		199		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58952									
ACOG		1.0	*	10	6.0		15	3.0	3.0
SGO		1.0	*	10	6.0		15	3.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfewk95	Sp	Phase	Twput	Iwput
58952									
ACOG		20		INCR	21.35	ob	3		0.036
SGO		20		33.00	21.35	ob	3		0.036

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 58960 Global Period: 090 Current RVW: 10.14 Recommended RVW: 16.55

CPT Descriptor: Laparotomy, for staging for restaging of ovarian malignancy ("second look"), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited periaortic lymphadenectomy

Source and Summary of Comment to HCFA on this service: ACOG: Requires total physician work approximately equivalent to CPT 49220, but work RVUs are lower for 58960.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59 year old woman completed 6 cycles of platinum-based chemotherapy following cytoreductive surgery for ovarian cancer. She now undergoes end-staging laparotomy. Multiple specimens of cytology washings of abdominal quadrants, pelvic and subdiaphragm, as well as multiple biopsies are taken. After hospital discharge, the patient receives office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Operative Work:

An incision is made. On opening the peritoneal cavity, care is taken to avoid injury to adherent loops of bowel from previous surgery. Peritoneal washings are taken and subdiaphragmatic scrapings are obtained for cytologic evaluation. Multiple biopsies are taken from the abdominal and pelvic peritoneum. A selected bilateral pelvic and paraaortic lymphadenectomy is performed. An omentectomy is done, if not done at the initial surgery. The abdomen is closed in layers. A dressing is applied.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 5 days. The patient is discharged on post op day 5 with instructions for follow-up care. The patient is reevaluated three times post operatively.

SURVEY DATA:

Specialty: ACOG

Sample Size: 112 Response Rate (%): 55 (49%) Median RVW: 16

25th Percentile RVW: 14.4 75th Percentile RVW: 17.8 Low: 11 High: 30.75

Median Pre-Service Time: 60 Median Intra-Service Time: 150

25th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 180 Low: 90 High: 300

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>---</u>	<u>---</u>
Other Hospital:	<u>75</u>	<u>5</u>
Office:	<u>40</u>	<u>3</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49220	Staging celiotomy	13.66
2)	38562	Limited lymphadenectomy	9.65
3)	49000	Exploratory laparotomy	8.99
4)	38770	Pelvic lymphadenectomy	12.10

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The intra-service work of CPT 58960 is approximately equivalent to the intra-service work for CPT 49220, except that CPT 58960 usually does not include a splenectomy. However, the technical skill and physical effort required to perform CPT 58960 is greater because of adhesions from previous surgery for the ovarian malignancy. In addition, stress associated with CPT 58960 is higher than for CPT 49220 because of the greater risk of bowel damage. The typical patient undergoing CPT 58960 also tends to be sicker because of having undergone chemotherapy, so post-operative work may be greater.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	150 x .06	-	9.00
Day of	99233	-	1.25
Hospital	99232	-	.88
	99231 x 3	-	1.53
	99238	-	1.06
Office	99214	-	.94
	99212	-	<u>.38</u>
			16.55

Public Comments

30-Jun-95

Code: 58960

1995 RVUs: 10.14

Recommended RVUs: Inc

Ratio:

Long Descriptor: Laparotomy, for staging or restaging of ovarian malignancy ("second look"), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited para-aortic lymphadenectomy

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 864 **Impact:**

Source: 1 **Year:** 92 **Public Comment Letter:** 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
58960	36.6	4.9	0	100	9.8	0	0	10

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
58960	1151	1014	-6.1

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
58960	96.2	97	0.4

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
58960	general surgery	27.9
	obstetrics/gynecology	67.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
58960	182	1.2	MALIGNANT NEOPLASM OF BODY OF U
	183	19	MALIGNANT NEOPLASM OF OVARY AND
	197	2.4	SECONDARY MALIGNANT NEOPLASM O
	220	1.2	BENIGN NEOPLASM OF OVARY

Public Comments

30-Jun-95

553	2.4	OTHER HERNIA OF ABDOMINAL CAVITY
568	2.4	OTHER DISORDERS OF PERITONEUM
789	2.4	OTHER SYMPTOMS INVOLVING ABDOM
V10	1.2	PERSONAL HISTORY OF MALIGNANT NE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
58960							
ACOG		090	090	9.95	10.14	1.02	10.14

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
58960								
ACOG	10.14	10.14	1.02	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
58960								
ACOG	090	9.95		33	*	107		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
58960									
ACOG	*	1.0	*	10	4.0	*	15	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
58960									
ACOG	*	15		INCR	10.14	ob	3		0.049

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 59100 Global Period: 090 Current RVW: 5.96 Recommended RVW: 11.54

CPT Descriptor: Hysterotomy, abdominal (eg, for hydatiform mole, abortion)

Source and Summary of Comment to HCFA on this service: ACOG: Requires greater mental effort, technical skill, and stress throughout the pre-, intra-, and post-service periods than CPT 49000, but has fewer work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 27 year old G4P3 female with a history of 3 previous cesarean sections is admitted with fetal death in utero at 20 weeks. The cervix is long and closed and leakage of amniotic fluid is noted. After admission, she is noted to be developing early signs of amnionitis. Antibiotics are begun and the patient undergoes hysterotomy. After hospital discharge, she receives follow-up care in the office during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

The surgery is similar to a cesarean section but the abdominal and uterine incisions are smaller. The lower abdominal wall is opened with either a vertical or horizontal incision, and the uterus is entered through the lower uterine segment. The embryo is removed along with any remaining membranes and placenta from the uterine cavity. The abdominal and uterine incisions are closed by suturing.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 4 days. The patient is discharged on post op day 4 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 200 Response Rate (%): 49 (25%) Median RVW: 1425th Percentile RVW: 11.08 75th Percentile RVW: 16 Low: 9 High: 20Median Pre-Service Time: 60 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 57.5 75th Percentile Intra-Svc Time: 90 Low: 30 High: 180

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>35</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>60</u>	<u>4</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	59515	Cesarean delivery including postpartum	16.55
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Intra-service work for CPT 59100 and CPT 59515 is very similar, except that the abdominal and uterine incisions required for CPT 59100 are smaller. Post-operative work is also similar. The recommended RVUs for CPT 59100 are lower, though, because the RVUs assigned to CPT 59515 reflect the work of managing labor which is not included in CPT 59100.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	60 min. x .075	-	4.50
Day of service	99233	-	1.25
Hospital	99232	-	.88
	99231 x 2	-	1.02
	99238	-	1.06
Office	99214	-	.94
	99212	-	<u>.38</u>
			11.54

Public Comments

30-Jun-95

Code: 59100 1995 RVUs: 5.96 Recommended RVUs: Inc Ratio:

Long Descriptor: Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)

Reference Set (y/n): N Global Period: 090 Frequency: 15 Impact:

Source: 1 Year: 92 Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ASRM 2

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
59100	29	12	-35.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
59100	34.5	50	7.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
59100	obstetrics/gynecology	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
59100							
ACOG		090	090	5.76	5.96	1.03	5.96

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
S9100								
ACOG	5.96	5.96	1.03	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
S9100								
ACOG	090	5.76		25	*	69		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
S9100									
ACOG	*	1.0	*	10	2.0	*	15	0.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
S9100									
ACOG	*	15		INCR	5.96	ob	3		0.039

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 59121 Global Period: 090 Current RVW: 6.99 Recommended RVW: 10.99

CPT Descriptor: Surgical treatment of ectopic pregnancy, tubal or ovarian without salpingectomy and/or oophorectomy

Source and Summary of Comment to HCFA on this service: ACOG: Requires more mental effort, technical skill, and stress than CPT 49000, but has lower work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36 year old gravida 2, para 1 presents with mild abdominal pain, vaginal spotting, elevating BhCG levels to 6000 without ultrasound evidence of an intrauterine gestation. she has a previous colostomy in place. The patient undergoes mini-laparotomy and is found to have a right ampullary unruptured ectopic gestation. This is evacuated with salpingostomy. After hospital discharge, the patient receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

An incision is made in the lower abdomen, and the pelvic cavity is explored. An inspection of the gestation site is performed for bleeding. All of the products of conception, clots, and free blood are removed. The embryo is manually removed from the tube by making a small incision in the tube. The pelvis is lavaged with saline solution and the incision is closed with sutures.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 150 Response Rate (%): 46 (31%) Median RVW: 1225th Percentile RVW: 10.2 75th Percentile RVW: 14 Low: 3.74 High: 19Median Pre-Service Time: 60 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 94 Low: 40 High: 120

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>45</u>	<u>3</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)			
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The mental effort and judgment required by CPT 59121 to decide whether the tube or ovary affected by the ectopic pregnancy can be salvaged and the technical skill required to complete this procedure are at least equivalent to, if not significantly greater than, the mental effort and technical skill required to perform CPT 49000. In addition, CPT 59121 is performed on an emergency basis on a patient who may be in shock from blood loss and is at high risk of post-operative infection and future loss of fertility so stress is higher for this procedure than for CPT 49000.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	78 min. x .06	-	4.68
Day of Procedure	99233	-	1.25
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99213 x 2	-	<u>1.1</u>
			10.99

Note: CPT 59121 is slightly less difficult than CPT 59120 because the patient is not as sick.

Public Comments

30-Jun-95

Code: 59121

1995 RVUs: 6.99

Recommended RVUs: Inc

Ratio:

Long Descriptor: Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy

Reference Set (y/n): N

Global Period: 090

Frequency: 12

Impact:

Source: 1

Year: 92

Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
59121	7	12	30.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
59121	71.4	50	-10.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
59121	general surgery	33.3
	obstetrics/gynecology	66.7

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
59121							
ACOG		090	090	7.04	6.99	0.99	6.99

Public Comments

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
59121								
ACOG	6.99	6.99	0.99	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
59121								
ACOG	090	7.04		27	*	54		40

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
59121									
ACOG	*	1.0	*	10	3.5	*	15	0.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
59121									
ACOG	*	15		INCR	6.99	ob	3		0.057

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 59130 Global Period: 090 Current RVW: 7.88 Recommended RVW: 14.94

CPT Descriptor: Surgical treatment of ectopic pregnancy, abdominal pregnancy

Source and Summary of Comment to HCFA on this service: ACOG: Requires approximately equivalent time, and significantly greater judgment, technical skill, and stress than CPT 49000, but has lower work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36 year old primigravida presents with elevating hCG levels to 6000 without evidence of intrauterine pregnancy and undergoes endoscopic pelvic evaluation with the findings of a mild hemoperitoneum of approximately 100 cc of blood in the cul-de-sac. Examination of the fallopian tubes and ovaries reveal no evidence of a tubal gestation. However, examination of the omentum behind the right adnexa suggests a fixed clot, which upon examination is the likely implantation site for an abdominal pregnancy. Because of the proximity to the transverse colon and the physician's inability to achieve adequate hemostasis endoscopically, an exploratory laparotomy is performed with partial omentectomy and removal of the abdominal pregnancy. After hospital discharge, the patient receives routine office follow-up care during the 90 day global period.

Note: The endoscopic evaluation can be coded separately as CPT 56300 and should not be included in your work RVU estimate.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

After making an abdominal incision, the fetus is removed from the abdomen. The membranes are also removed and the cord is ligated near the placenta. Abdominal lavage is performed and the abdominal incision is closed with sutures.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 150 Response Rate (%): 35 (23%) Median RVW: 13.4925th Percentile RVW: 10.5 75th Percentile RVW: 15.7 Low: 9.5 High: 20Median Pre-Service Time: 60 Median Intra-Service Time: 12025th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 120 Low: 45 High: 210

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>60</u>	<u>3</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49000	Exploratory laparotomy	8.99
2)	59515	Cesarean section with post-op care	16.55
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Total work required for CPT 59130 is approximately equivalent to the total work required for CPT 59515. While CPT 59130 does not include the work of managing labor, this is outweighed by the much higher level of stress and greater intra-service time associated with CPT 59130.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	120 min. x .075	-	9
Day of Procedure	99233	-	1.25
Hospital	99213 x 2	-	1.02
	99238	-	1.06
Office	99213 x 2	-	<u>1.1</u>
			14.94

Public Comments

30-Jun-95

Code: 59130

1995 RVUs: 7.88

Recommended RVUs: Inc

Ratio:

Long Descriptor: Surgical treatment of ectopic pregnancy, abdominal pregnancy

Reference Set (y/n): N Global Period: 090 Frequency: 1 Impact:

Source: 1 Year: 92 Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
59130	.	2	.

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
59130	.	100	.

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
59130	obstetrics/gynecology	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
59130							
ACOG		090	090	7.71	7.88	1.02	7.88

Harvard Data:

Public Comments

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
59130								
ACOG	7.88	7.88	1.02	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
59130								
ACOG	090	7.71						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
59130									
ACOG									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
59130									
ACOG				INCR	7.88	ob	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 59136 Global Period: 090 Current RVW: 8.69 Recommended RVW: 13.06

CPT Descriptor: Surgical treatment of ectopic pregnancy, interstitial, uterine pregnancy with partial resection of the uterus

Source and Summary of Comment to HCFA on this service: ACOG: Requires approximately equivalent time, and significantly greater judgment, technical skill, and stress than CPT 49000, but has slightly lower work RVUs.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26 year old woman with a history of post medical treatment for pelvic inflammatory disease presents with right lower quadrant abdominal pain, BhCG level of 4000, and pelvic ultrasound findings suggestive of an ectopic gestational sac in the proximal left fallopian tube or uterine cornua. An exploratory laparotomy is performed with findings of a cornual pregnancy. This is injected and resected with proximal resection of the fallopian tube. After hospital discharge, the patient receives routine office follow-up care during the 90 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

An exploratory laparotomy is performed with findings of a cornual pregnancy. The uterine wall is resected and then reconstructed. The proximal portion of the fallopian tube is also resected. Pelvic lavage is performed and the abdominal incision is closed with sutures.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated twice post operatively.

SURVEY DATA:Specialty: ACOGSample Size: 150 Response Rate (%): 40 (27%) Median RVW: 12.525th Percentile RVW: 11.21 75th Percentile RVW: 14 Low: 9.78 High: 17Median Pre-Service Time: 60 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 65 75th Percentile Intra-Svc Time: 120 Low: 60 High: 180

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>40</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>45</u>	<u>3</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	51860	Cystorrhaphy - simple	11.17
2)	51865	Cystorrhaphy - complicated	13.99
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 59136 requires slightly less work than CPT 51865.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	90 min. x .075	-	6.75
Day of procedure	99233	-	1.25
Hospital	99232	-	.88
	99231	-	.51
	99238	-	1.06
Office	99213 x 2	-	<u>1.1</u>
			13.06

Public Comments

30-Jun-95

Code: 59136

1995 RVUs: 8.69

Recommended RVUs: Inc

Ratio:

Long Descriptor: Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy with partial resection of uterus

Reference Set (y/n): N

Global Period: 090

Frequency: 1

Impact:

Source: 4

Year: 93

Public Comment Letter: 310

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACOG, ASRM 2

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
59136	1	.	.

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
59136	100	.	.

Trends Analysis – Specialty Mix:

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
59136							
ACOG		090	090	9.12	8.69	0.95	8.69

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
59136								
ACOG	8.69	8.69	0.95	1.00	1.00	1.00	INCR	310

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
59136								
ACOG	090	9.12						

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
59136									
ACOG									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
59136									
ACOG				INCR	8.69	ob	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 59841 Global Period: 010 Current RVW: 3.24 Recommended RVW: 5.45

CPT Descriptor: Induced abortion, by dilation and evacuation

Source and Summary of Comment to HCFA on this service: ACOG: Typical patient has changed since establishment of RVUs. Gestational length of pregnancies terminated with this method now longer, increasing level of skill required and the risk of the procedure.

NAF and AGI: Undervalued in comparison to 59840. The difference in RVUs does not reflect the difference in work.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A pregnant woman at 18 weeks gestation presents for termination of pregnancy. She has already received extensive counseling about the procedure. She now undergoes dilation and evacuation under appropriate anesthesia. She is observed for 6 hours post-operatively and discharged home with dietary and post-operative activity instructions. She has an uneventful recovery and receives routine follow-up care during the 10 day global period.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician may admit the patient to the hospital and if so must prepare the hospital records and chart in accordance with hospital policy, check on the patient, and review records prior to the surgery. If done in an outpatient setting, the chart is documented. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient. Cervical dilators were used several hours to several days prior to the procedure and are not part of the pre-service work.

Description of Intra-Service Work:

A speculum is inserted into the vagina to view the cervix. A tenaculum is used to grasp the cervix, pull it down, and exert traction. A cannula is placed in the dilated endocervical canal and passes it into the uterus. The suction machine is then activated and the uterine contents are evacuated by rotation of the cannula. Since this pregnancy is later than 16 weeks, the cannula is used to drain amniotic fluid and to draw tissue into the lower uterus for extraction by forceps. A sharp curet may also be used to scrape the uterus to ensure that it is empty.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The patient is discharged the same day with instructions for follow-up care. The patient is reevaluated once post operatively.

SURVEY DATA:

Specialty: ACOG

Sample Size: 60 Response Rate (%): 25 (42%) Median RVW: 4.8

25th Percentile RVW: 4.26 75th Percentile RVW: 6.5 Low: 3.59 High: 14.6

Median Pre-Service Time: 45 Median Intra-Service Time: 35

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 57 Low: 15 High: 100

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45</u>	
ICU:	<u>----</u>	<u>----</u>
Other Hospital:	<u>30</u>	<u>1</u>
Office:	<u>30</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	59820	Treatment of missed abortion - first trimester	3.73
2)	59821	Treatment of missed abortion - second trimester	4.26
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 59841 requires greater technical skill and entails greater skill than CPT 59821 because of the greater difficulty of terminating a continuing pregnancy and a higher risk of excessive bleeding and infection.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-service	99215	-	1.51
Intra-service	35 min. x .05	-	2.0
Day of procedure	99233	-	1.25
Office	99214	-	<u>.94</u>
			5.45

Note: We believe that since the late 1980s, the profile of patients undergoing an abortion by dilation and evacuation has changed, so that it is now undervalued in comparison to CPT 59840 (Induced abortion, by dilation and curettage). According to the most recent data available from the Centers for Disease Control, more than 87 percent of abortions occur within the first twelve weeks of gestation (the first trimester).

It appears that there has been a shift in the choice of medical technique used to perform the relatively few abortions that occur in the later second trimester and therefore a change in the typical patient undergoing abortion by dilation and evacuation (CPT 59841). Specifically, a higher proportion of the pregnancies terminated by this method are now greater than 16 weeks gestation. The physician work associated with CPT 59841 increases with the length of gestation. More time and greater skill are required for safe completion of the procedure. In addition, the technique itself differs slightly. For pregnancies through 16 weeks, the physician places a cannula in the dilated endocervical canal, the suction machine is activated, and the uterine contents are evacuated by rotation of the cannula. For later pregnancies, the cannula is used to drain the amniotic fluid and to draw tissue into the lower uterus for extraction by forceps. In addition to the difference in intra-service work, patients undergoing a later second trimester abortion require closer follow-up because of the increased risk of infection and hemorrhage.

Data on induced abortion are notoriously out-of-date and incomplete. Information from the Centers for Disease Control Reproductive Health Surveillance Branch reported in **Morbidity and Mortality Weekly Report**, though, are suggestive of a trend toward increasing use of dilation and evacuation for later second trimester abortions. Between 1982 and 1990, the proportion of all abortions that were performed at 16 or more weeks gestation remained constant at about 5 percent. However, the distribution of abortions by technique did change. Over this time period, the proportion of abortions performed by intrauterine saline installation or prostaglandin installation (techniques only used in the late second trimester) declined from 2.5% to 0.8% of all abortions. This change was accompanied by a rise in the percentage of abortions performed by suction curettage (which includes dilation and evacuation) from 89.9% in 1982 to 94% in 1990.

Public Comments

30-Jun-95

Code: 59841

1995 RVUs: 3.24

Recommended RVUs: Inc

Ratio:

Long Descriptor: Induced abortion, by dilation and evacuation

Reference Set (y/n): N Global Period: 010 Frequency: 140 Impact:

Source: 16 Year: 93 Public Comment Letter: 310

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACOG

Societies Wishing to Comment: ASRM 2

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
59841	0	0	50	100	100	0	0	0

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
59841	107	150	18.4

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
59841	18.7	18.7	0

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
59841	group practices	12
	obstetrics/gynecology	85.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
59841	635	12.5	LEGALLY INDUCED ABORTION
	650	12.5	DELIVERY IN A COMPLETELY NORMAL

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packdv	Pack95	Hrvtotwk	Mfewk95	Ratio5h	Mfewk92
59841							
ACOG		090	010	2.88	3.24	1.13	3.24
Clinic		090	010	2.88	3.24	1.13	3.24
NAF		090	010	2.88	3.24	1.13	3.24

Harvard Data:

Comm	Mswk93	Mfewk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
59841								
ACOG	3.24	3.24	1.13	1.00	1.00	1.00	INCR	310
Clinic	3.24	3.24	1.13	1.00	1.00	1.00	INCR	478
NAF	3.24	3.24	1.13	1.00	1.00	1.00	INCR	303

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
59841								
ACOG	010	2.88		19		26		
Clinic	010	2.88		19		26		
NAF	010	2.88		19		26		

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
59841									
ACOG		0.0		0	0.0		0	0.0	1.0
Clinic		0.0		0	0.0		0	0.0	1.0
NAF		0.0		0	0.0		0	0.0	1.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfewk95	Sp	Phase	Twput	lwput
59841									
ACOG		15		INCR	3.24	ob	3		0.048
Clinic		15		INCR	3.24	ob	3		0.048
NAF		15		INCR	3.24	ob	3		0.048

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE RBRVS FIVE-YEAR REVIEW

RUC RECOMMENDATIONS

Neurosurgery

Comments

The American Association of Neurological Surgeons/Congress of Neurological Surgeons (AANS) submitted comments to HCFA identifying 73 misvalued services, both under- and overvalued. The comments presented a detailed history of the RBRVS for neurosurgery, identifying several problems in the methodology and results of the original Harvard study, particularly in the change from intraoperative work to total work and in the cross-specialty linkage process, and in review by refinement panels. The basic problem is attributed to the Harvard cross-specialty linkage process distorting and compressing the within-neurosurgery relative work ratings. Although this was corrected to some degree in Phase 3 of the study, the 1992 refinement panels did not accept many of the final Harvard numbers for neurosurgical procedures. Even the final Harvard data contain errors in data on postservice work, and they often do not assume any ICU visits when at least several would be provided by the neurosurgeon.

Most of the arguments presented focus on the nontemporal components of physician work, described as "intensity." The comments explain that the current RVUs do not accurately reflect the varying levels of intensity for different neurosurgical procedures, nor within the different components of each service. To identify the specific codes that are misvalued in the current scale, the AANS conducted a survey in 1994. A representative sample of 200 neurosurgeons was surveyed to evaluate in detail the time and intensity of key reference services for neurosurgery using the same categories of time and intensity provided by HCFA in the December 8, 1994 Rule. Surveyed physicians were not asked to reevaluate the total work RVUs for these procedures, however. The time data gathered from this study, which included detailed operative logs on over 1,500 neurosurgical patients, was found to correspond closely to the final Harvard Phase 3 data, and the AANS concluded that the survey provided good validation for the Harvard results for this component of work. The study also attempted to directly measure mental effort and judgement, technical skill and physical effort, and psychological stress, rather than calculating it as a ratio of work to time. This allows for more variation within each component of intensity and greater precision in calculating relative values. This research confirmed the problems initially identified by the AANS, with pre- and postwork for some of the most complex procedures underestimated by 30-40%.

The focus of the AANS comments is on appropriately valuing the codes within neurosurgery by adjusting the rank orders upwards and downwards. To develop its recommendations to the RUC, the AANS conducted a second survey in 1995, which led to some adjustments in the recommended

CPT five-digit codes, two-digit modifiers, and descriptions are copyright by the American Medical Association.

KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five-year review.

RVUs. In addition, the AANS identified five more misvalued codes that had not been mentioned in its comments to HCFA. The RUC believes it is important to add these codes to the five-year review in order to have correct rank ordering of codes across neurosurgical procedures.

RUC Rationale

The RUC evaluated the approach used to calculate the recommended RVUs and considered it to be reasonable. There was some discussion of "lumping" vs. "splitting," as the AANS methodology of measuring intensity "splits" it out from overall work. On the other hand, the time periods used by the AANS were the same ones used by Harvard, and the time estimates are based on objective data, not on surgeons' opinions about how much time they spend doing each component of work. In fact, for a number of the services studied by the AANS, the resulting RVUs tended to validate the final RVUs from the Harvard RBRVS study. For example, code 61480 [*Craniectomy, suboccipital; for mesencephalic tractotomy or pedunculotomy*] currently has 16.77 RVUs, but the final Harvard RVUs for the service are 25.55 RVUs and the neurosurgery study produced a recommended value of 25.03 RVUs.

The effort appeared to the RUC more as an attempt to bring a higher degree of precision to the relative values for neurosurgery than to split work into more components in order to inflate the relative values. The recommended reductions in some higher frequency codes (i.e., code 63030, *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar*, is reduced from 12.11 to 11.10 RVUs and had a frequency of 29,103 in 1994) bolstered this perception. In addition, a number of very low frequency services, including some pediatric codes, were included in the analysis and recommendations (i.e., *Craniectomy, suboccipital; for mesencephalic tractotomy or pedunculotomy*, which had zero claims in 1994). Services which are both highly specialized and very infrequently provided may not have received sufficient attention in the Harvard study. In addition to the individual recommendation forms and data reports, a summary of the AANS arguments and methodology is attached to this recommendation.

To evaluate the results of this approach, the RUC workgroup, which included a general surgeon, an ophthalmologist, and a psychiatrist, first selected out a number of the codes and calculated two ratios: (1) recommended total work RVUs/intraservice time, and (2) recommended total work RVUs/total time. The results of this analysis were very consistent with one another and with other codes on the RBRVS, with nearly all of the codes having a ratio of RVUs to total time of about 0.05 and ratios of RVUs to intratime of 0.10 to 0.14. The highest intrawork ratio was 0.178 for code 61700 [*Surgery of intracranial aneurysm, intracranial approach; carotid circulation*, 48.30 RVUs recommended], and this was found to be appropriate because of the extremely complex and difficult nature of this service, when compared to both other codes within the family of intracranial vascular codes and other major neurosurgical services:

The degree of mental effort and judgement are very high in all three phases of the service, beginning with the immediate preservice decisions regarding the optimal management strategies appropriate to the individual patient circumstances. The intraservice phase requires a sustained near maximal level of judgmental effort to apply to the particular details of the approach, the local anatomy, and the variations in aneurysmal relationships to parent vessels, as well as adjacent neural structures. Small errors at this phase can be lethal. The postservice phase on average requires

five ICU visits, with a very high level of mental input to the frequent problems that occur following this operation, including the development of hydrocephalus or reactive vasospasm due to the blood products released into the subarachnoid space following the original aneurysmal hemorrhage. The contribution of technical skill and effort during the intraservice phase was rated by over 100 neurosurgeons at near maximum for the majority of the 270 minutes of operative time. This was not the typical spiked peak of intensity common to many operations, but was a sustained level of very high technical skill, since virtually all of these procedures are done under high magnification and are dealing with very small structures situated deep beneath the anterior portion of the brain and commonly proximate to the optic nerve and internal carotid artery and branches. The stress and risk component of intensity was also ranked very high by all respondents due to the high morbidity associated with a major subarachnoid hemorrhage as well as the risks of damage to major vessels or neural structures during the aneurysmal dissection and clipping. The stress factor centers on the risk of early rebleeding from the aneurysm before surgery and management of intracranial hypertension. It extends into the postservice phase due to the frequent development of stroke symptoms due to brain ischemia following vasospasm.

The RUC then selected several of the codes for comparison with codes on the MPC with which they were familiar:

- Code 61682 [*Surgery of intracranial arteriovenous malformation; supratentorial, complex, 59.47 RVUs recommended*] was compared with 33870 for transverse aortic arch graft, which has 37.74 RVUs. This service involves the surgical efforts to obliterate and remove a congenital vascular malformation from within the brain, frequently deep within a cerebral hemisphere. Many of the issues that contribute to the high complexity of 61700 also apply to this service, although pre- and postwork complexity is somewhat lower. This service requires 420 minutes of intraoperative time, however, compared to 270 minutes for 61700.
- Code 67107 for repair of retinal detachment (13.99 RVUs) was compared to code 61875 for implantation of neurostimulator electrodes (13.79 RVUs recommended). The intrawork ratio for retinal detachment is 0.13 and the total work ratio is 0.049; for the neurosurgery code the intrawork ratio is 0.115 and the total work ratio is 0.04. The ratio comparisons and the work and time involved in each service appear to be correct. Code 67107 involves 107 minutes of intraoperative time, and code 61875 involves 120 minutes of intraoperative time. The final Harvard RVUs for code 61875 are 14.06.
- The comparison of code 61702 for surgery of intracranial aneurysm (46.31 RVUs recommended) to code 48150 (Whipple procedure, 42.53 RVUs) also seems correct, since 61702

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five-year review.

involves surgery of a vertebral or basilar artery aneurysm and has the same high levels of mental effort, technical skill, and stress/risk outlined above for 61700.

The RUC concluded that the neurosurgery study produced relative value recommendations that are considerably more precise than the current RVUs for these services.

Three codes in this section were identified for review by the CMDs as well as the AANS, and the RUC reviewed each of these recommendations individually:

- For code 61791 [*Creation by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract, 7.29 RVUs*], the CMDs recommended an increase to 13.29 RVUs because the service is substantially more difficult than 61790 for treatment of trigeminal nerve (10.31 RVUs). The RUC recommends a somewhat higher increase to 13.99 RVUs rather than the 13.29 RVUs recommended by the CMDs. The Harvard RVUs for this service are 14.28 RVUs.
- For code 62290 [*Injection procedure for diskography, each level; lumbar, 3.58 RVUs*], the CMDs recommended a reduction to 2.05 RVUs, which would be 25% more than code 62289 for epidural or caudal injection. The RUC agreed with the AANS that 62289 is a poor reference for code 62290 because the techniques are not very comparable and the targets and risks are different. Code 62291 [*Injection procedure for diskography, single or multiple, cervical, 2.91 RVUs*] is considered a better reference. The Harvard time appeared to apply only to a single level study, with a much longer time needed for a two-level or multiple study. 62290 should be reduced from 3.58 to 3.00 RVUs to allow for the fact that lumbar diskography is inherently more difficult than cervical diskography and still correct the rank order problem of the current RVUs.
- For code 64443 [*Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, each additional level, 1.35 RVUs*], the CMDs recommended the code be valued at 50% of code 64442 because it is an add-on code and does not involve pre- and postwork. Although the general rule of major surgical procedures that about 50% of the work is intra- and 50% is pre- and post-, this does not hold true for many minor procedures. In fact, the RVUs for code 64443 were already reduced significantly when the global period was changed. For 64442 and 64443, the AANS found that intrawork is 61% of total work. The RUC recommends, therefore, that the RVUs for 64443 be reduced to 0.98 from 1.35, but not to 0.78 as recommended by the CMDs.

The RUC considered recommending that all the neurosurgery codes in the five-year review be rescaled to make the changes work neutral. Although the AANS recommended changes in a very

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five-year review.

large number of codes, because some of them have zero or very few Medicare claims annually and because reductions were recommended in some of the high frequency codes, such as 63030 for low back disk surgery, the overall impact of the recommendations is relatively small. An AMA analysis using 1994 frequency data found that acceptance of the recommended changes would increase Medicare expenditures by about \$3.8 million. Rescaling the recommended values to make them work neutral would have required nearly a 4% reduction in all the recommended values, however, and this would have made some of them, particularly those for which reductions are recommended, too low. The RUC recommends, therefore, that all the recommended changes be adopted without any rescaling.

Code	Descriptor	95 RVU	RUC Rec RVU	Key
22849	Removal of anterior instrumentation	12.86	17.55	1
22855	Removal of anterior instrumentation	9.10	14.11	1
61020	Remove brain cavity fluid	1.51	1.51	2
61026	Injection into brain canal	1.69	1.69	2
61105	Drill skull for examination	8.19	4.82	3
61106	Drill skull for exam/surgery	7.35	4.62	3
61107	Drill skull for implantation	4.35	5.00	1
61108	Drill skull for drainage	10.80	9.00	3
61120	Pierce skull for examination	9.31	8.00	3
61210	Pierce skull; implant device	4.72	5.84	1
61215	Insert brain-fluid device	10.05	4.00	3
61250	Pierce skull & explore	11.03	9.40	3
61253	Pierce skull & explore	13.00	11.27	3
61312	Open skull for drainage	20.54	21.83	1
61313	Open skull for drainage	20.54	22.50	1
61330	Decompress eye socket	15.65	21.55	1
61340	Relieve cranial pressure	11.56	17.33	1

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61470	Incise skull for surgery	20.79	24.60	1
61480	Incise skull for surgery	16.77	25.03	1
61490	Incise skull for surgery	15.63	24.20	1
61510	Removal of brain lesion	23.39	26.77	1
61512	Remove brain lining lesion	24.26	33.51	1
61518	Removal of brain lesion	32.27	35.59	1
61519	Remove brain lining lesion	33.84	39.58	1
61520	Removal of brain lesion	38.35	52.98	1
61521	Removal of brain lesion	39.48	42.20	1
61526	Removal of brain lesion	29.71	50.59	1
61531	Implant brain electrodes	20.50	12.95	3
61533	Implant brain electrodes	23.41	18.05	3
61536	Removal of brain lesion	29.43	33.49	1
61538	Removal of brain tissue	28.05	25.09	3
61539	Removal of brain tissue	30.05	30.05	2
61542	Removal of brain tissue	27.39	29.05	1
61543	Removal of brain tissue	20.62	27.32	1
61545	Excision of brain tumor	34.50	41.76	1
61576	Skull base/brainstem surgery	33.82	50.08	1
61680	Intracranial vessel surgery	36.45	29.13	3
61682	Intracranial vessel surgery	42.21	59.47	1
61684	Intracranial vessel surgery	39.25	38.23	3
61686	Intracranial vessel surgery	47.45	62.08	1
61690	Intercranial vessel surgery	33.82	27.80	3 add
61692	Intracranial vessel surgery	37.96	49.74	1
61700	Inner skull vessel surgery	34.83	48.30	1
61702	Inner skull vessel surgery	39.20	46.31	1
61720	Incise skull/brain surgery	15.85	15.92	1

61735	Incise skull/brain surgery	17.08	18.72	1
61750	Incise skull; brain biopsy	10.03	16.67	1
61751	Brain biopsy with cat scan	15.18	16.66	1
61760	Implant brian electrodes	24.83	21.00	3
61770	Incise skull for treatment	15.14	19.78	1
61791	Treat trigeminal tract	7.29	13.99	1
61793	Focus radiation beam	16.70	17.88	1
61850	Implant neuroelectrodes	15.98	11.50	3
61855	Implant neuroelectrodes	12.94	12.50	3
61860	Implant neuroelectrodes	11.20	19.60	1
61865	Implant neuroelectrodes	21.70	21.70	2 add
61870	Implant neuroelectrodes	5.77	13.67	1
61875	Implant neuroelectrodes	9.20	13.79	1
61885	Implant neuroreceiver	2.35	5.28	1
61888	Revise/remove neuroreceiver	3.10	4.67	1
62180	Establish brain cavity shunt	12.72	19.71	1
62194	Replace/irrigate catheter	2.81	4.50	1
62200	Establish brain cavity shunt	13.24	17.33	1
62201	Establish brain cavity shunt	12.10	13.54	1
62223	Establish brain cavity shunt	12.81	11.96	3
62268	Drain spinal cord cyst	3.87	4.74	1
62269	Needle biopsy spinal cord	4.07	5.02	1
62287	Percutaneous diskectomy	4.13	7.43	1

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five-year review.

62290	Inject for spine disk x-ray	3.58	3.00	3
62294	Injection into spinal artery	8.05	10.95	1
63005	Removal of spinal lamina	13.53	13.88	1
63011	Removal of spinal lamina	11.11	13.40	1
63015	Removal of spinal lamina	16.59	17.77	1
63017	Removal of spinal lamina	15.85	14.90	3
63020	Neck spine disk surgery	12.53	13.77	1 add
63030	Low back disk surgery	12.11	11.10	3
63042	Low back disk surgery	17.27	16.56	3
63047	Removal of spine lamina	12.76	13.57	1 add
63057	Decompress spinal cord	3.00	5.26	1
63075	Neck spine disk surgery	19.77	18.50	3
63087	Removal of vertebral body	27.56	33.91	1 add
63655	Implant neuroelectrodes	8.95	9.30	1
63740	Install spinal shunt	10.43	10.37	3
63741	Install spinal shunt	7.13	7.57	1
63744	Revision of spinal shunt	6.83	7.34	1
63750	Insert spinal canal catheter	7.23	7.81	1
64443	Injection for nerve block	1.35	0.98	3

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five-year review.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 22849 Global Period: 090 Current RVW: 12.86 Recommended RVW: 17.55

CPT Descriptor: Removal of anterior instrumentation.

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended increase in RVW from 12.86 to 17.55.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Harvd3	AANS	Harvd3 to MFS95	MFS95	Rel. New RVW
22852	REMOVAL POST. SEGMENTAL INSTRUMENTATION	58	68		84	890		8.66	8.40	
22842	INSERT POST. SPINE FIXATION DEVICE		120				1224		14.42	12.18
22855	REMOVAL ANTERIOR INSTRUMENTATION	69	136		136	1418		14.11	9.10	14.11
22849	REINSERT SPINE FIXATION DEVICE	71	121		126	1763		17.55	12.86	17.55
63075	DISSECTOMY, ANTERIOR APPROACH, WITHOUT FUSION SINGLE CERVICAL	64	138		115	1362		13.56	19.77	
63075	DISSECTOMY, ANTERIOR APPROACH, WITHOUT FUSION SINGLE CERVICAL	64	120		126	1421		14.21	18.50	AANS
63077	DISSECTOMY, ANTERIOR APPROACH, WITHOUT FUSION SINGLE THORACIC	79	202		145	2113		21.03	20.25	
63081	VERTEBRAL CORPECTOMY, ANT. DECOMPR. CORD, CERV. SINGLE SEGMENT	76	175		169	2200		21.90	22.08	

RELATIONSHIP OF 22849 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference services for this service are 22852 (REMOVAL POST. SEGMENTAL INSTRUMENTATION) and 22842 (INSERT POST. SPINE FIXATION DEVICE). The work involved in this service, 22849, is more than that for 22852 and 22842, which matches the Harvard3 total work values as well as the ascending scale of recommended RVWs. The MFS95 RVW for 22849 is out of scale with the associated service RVWs as illustrated in the table above, and it appears that the total Harvard3 work value is a more appropriate valuation of the service, with the converted RVW of 17.55 which matches the Harvard3 RVW converted from the total work value. This is our recommendation for a change in this code.

Several of the anterior discectomy codes are included for perspective on the total RVWs for services from an anterior approach.

PT Code: 22855

RATIONALE for recommendation:

Work:	Changes in past 5 years	Increased frequency of the spinal instrumentation services.
	Rank Order (Ordinal) Valuation:	Rank order of recommended RVWs in table appropriate as listed.
	Initial crosswalk or extrapolation misvaluation:	Initial total work was 1763.
Time:	Harvard3 Database:	As above.
	Mental Effort & Judgement:	Mental effort and judgement above that of 22852.
	Technical Skill & Physical Effort:	Greater than 22852.
	Stress:	Stress levels comparable across reference codes.
	Complexity:	Harvard3 intensity 10.19 compared to Harvard3 intensity of 6.33 for 22855.

Public Comments

30-Jun-95

Code: 22849

1995 RVUs: 12.86

Recommended RVUs: 17.55

Ratio:

Long Descriptor: Reinsertion of spinal fixation device

Reference Set (y/n): N

Global Period: 090

Frequency: 177

Impact: 830

Source: 1

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS, AAOS, AAP

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
22849	149	228	23.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
22849	98.7	97.4	-0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
22849	general/family practice	2.6
	group practices	3.5
	neurological surgery	18.4
	orthopedic surgery	74.6

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
22849							

Public Comments

30-Jun-95

AANS	090	090	17.90	12.86	0.72	12.86
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
22849								
AANS	12.86	12.86	0.72	1.00	1.00	1.00	17.55	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
22849								
AANS	090	17.90		36	*	121		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
22849									
AANS	*	1.0	*	10	5.5	*	10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
22849									
AANS	*	10	j	17.55	12.86	or	3		0.104

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 22855 Global Period: 090 Current RVW: 9.10 Recommended RVW: 14.11

CPT Descriptor: Removal of anterior instrumentation.

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended increase in RVW from 9.10 to 14.11.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Harvd3	AANS	Harvd3 to MFS95	MFS95	Rec.New RVW
22852	REMOVAL POST. SEGMENTAL INSTRUMENTATION	58	68		84	890		8.86	8.40	
22842	INSERT POST. SPINE FIXATION DEVICE		120				1224		14.42	12.18
22855	REMOVAL ANTERIOR INSTRUMENTATION	69	136		136	1418		14.11	9.10	14.11
22849	REINSERT SPINE FIXATION DEVICE	71	121		126	1753		17.55	12.86	17.55
63075	DISSECTOMY, ANTERIOR APPROACH, WITHOUT FUSION, SINGLE CERVICAL	64	138		115	1362		13.56	19.77	
63075	DISSECTOMY, ANTERIOR APPROACH, WITHOUT FUSION, SINGLE CERVICAL	90	120		125	1471		18.50		AANS54
63077	DISSECTOMY, ANTERIOR APPROACH, WITHOUT FUSION, SINGLE THORACIC	79	202		145	2113		21.03	20.25	
63081	VERTEBRAL CORPECTOMY, ANT. DECOMP. CORD, CERV. SINGLE SEGMENT	76	175		169	2200		21.90	22.08	

RELATIONSHIP OF 22855 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference services for this service are 22852 (REMOVAL POST. SEGMENTAL INSTRUMENTATION) and 22849 (REINSERT SPINE FIXATION DEVICE). The work involved in this service, 22855, is more than that for 22852 and less than 22849, which matches the Harvard3 total work values as well as the ascending scale of recommended RVWs. The MFS95 RVW for 22855 is out of scale with the associated service RVWs as illustrated in the table above, and it appears that the total Harvard3 work value is a more appropriate valuation of a service, with the converted RVW of 14.11. This is our recommendation for a change in this code.

Several of the anterior discectomy codes are included for perspective on the total RVWs for services from an anterior approach.

CPT Code: 22855

RATIONALE for recommendation:

Work:

Changes in past 5 years
Rank Order (Ordinal) Valuation:
Initial crosswalk or extrapolation misvaluation:

Increased frequency of the spinal instrumentation services.
Rank order of recommended RVWs in table appropriate as listed.
Initial total work was 1418.

Time:

Harvard3 Database:

As above.

Mental Effort & Judgement:

Mental effort and judgement above that of 22852.

Technical Skill & Physical Effort:

Greater than 22852, sl. less than 22849..

Stress:

Stress levels comparable across reference codes.

Intensity/Complexity:

Harvard3 intensity 6.33 compared to Harvard3 intensity of 10.19 for 22849.

Public Comments

30-Jun-95

Code: 22855

1995 RVUs: 9.1

Recommended RVUs: 14.11

Ratio:

Long Descriptor: Removal of anterior instrumentation

Reference Set (y/n): N

Global Period: 090

Frequency: 172

Impact: 862

Source: 1

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS, AAOS, AAP

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
22855	0	0	0	0	0	0	0	100

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
22855	97	175	34.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
22855	92.8	96.6	1.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
22855	neurological surgery	70.9
	neurology	2.3
	orthopedic surgery	25.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
22855	722	25	INTERVERTEBRAL DISC DISORDERS

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
22855							
AANS		090	090	14.41	9.10	0.63	9.10

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
22855								
AANS	9.10	9.10	0.63	1.00	1.00	1.00	14.11	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
22855								
AANS	090	14.41		35	*	136		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
22855									
AANS	*	1.0	*	10	6.0	*	10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
22855									
AANS	*	10	j	14.11	9.10	or	3		0.064

PROCEDURE CODES SELECTED FOR COMMENT AS MISVALUED

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61107 Global Period: 000 Current RVW: 4.35 Recommended RVW: 5.00

CPT Descriptor: Twist drill hole for subdural or ventricular puncture; for implanting ventricular catheter or pressure recording device

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended an increase in RVW from 4.35 to 5.00.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61106	TWIST DRILL/SUBDURAL OR VENTRIC PUNCT W OTHER SURGERY	43	25		13	462		4.62	7.35	4.62
61105	TWIST DRILL HOLE/SUBDURAL OR VENTRIC PUNCT	46	27		46	560		5.57	8.19	4.82
61107	TWIST DRILL HOLE/AMPLANT VENTRIC CATH OR RECORDING DEVICE	45	31		45	439		438	4.35	5.00
61130	BURR HOLE(S)/VENTRIC.TAP FOLL.BY OTHER SURGERY	47	33		22	585		4.48	6.37	
54	BURR HOLES (EVACUATION OF HEMATOMA, EXTRA- OR SUBDURAL UNILATERAL	65	69		176	1210	1361	12.06	13.67	

RELATIONSHIP OF 61107 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

This service also has a Global period of 000 which means that only the intra-service work relates to the RVW. This code compares most closely to 61106 examined above, also with a Global of ZZZ which excludes the post-service work. We surveyed this procedure and obtained data only for the intra-service time, which measured 30 minutes compared to the 31 minutes reported in Harvard3. However, Harvard3 included pre- and post-service time and work in their calculations, since the Global period was changed to ZZZ subsequent to the Harvard study and the original MFS in 1992 which had a RVW of 8.69. Code 61107 requires more work than 61105 or 61106, including the implantation of a ventricular catheter or recording device, plus the work of connection to an external drainage &/or recording system under aseptic conditions. Since we did not survey on the same basis, we are using rank order comparison to recommend a RVW of 5.00.

RATIONALE for recommendation:

<p>Work:</p> <p>Changes in past 5 years</p> <p>Rank Order (Ordinal) Valuation:</p> <p>Initial crosswalk or extrapolation misvaluation:</p> <p>Prev. RUC or Refinement Valuation:</p>	<p>Improved packaging of equipment to do this service past 5 years. Key to adjusting RVWs within this family of codes.</p> <p>61107 refinement in 1992 reduced RVW from 8.69 to 4.59 by the amount of work attributed to post-service followup, with change to ZZZ from 090.</p>
<p>Time:</p> <p>Op. Logs:</p> <p>AANS94 Survey Key Refs:</p> <p>Harvard3 Database:</p> <p>Undervalued time/Phase I or II & MFS92:</p>	<p>Intra-service time surveyed at 30 min.</p> <p>Harvard3 Pre- and Post- time overvalued due to original global 090.</p>
<p>Mental Effort & Judgement:</p> <p>Technical Skill & Physical Effort:</p>	<p>Slightly greater skill to do same service as 61105 with implantation of a ventricular catheter..</p>
<p>Stress:</p> <p>Intensity/Complexity:</p>	<p>More complex than 61105 or 61106.</p>

Public Comments

30-Jun-95

Code: 61107

1995 RVUs: 4.35

Recommended RVUs: 5.00

Ratio:

Long Descriptor: Twist drill hole for subdural or ventricular puncture; for implanting ventricular catheter or pressure recording device

Reference Set (y/n): N Global Period: 000 Frequency: 2,273 Impact: 1477

Source: 17 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61107	43.2	6.8	15.9	59.1	11.4	0	2.3	4.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61107	2041	2422	8.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61107	97.6	98.7	0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61107	group practices	4.9
	neurological surgery	90.6
	neurology	2.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61107	191	1.1	MALIGNANT NEOPLASM OF BRAIN
	331	2.8	OTHER CEREBRAL DEGENERATIONS
	348	1.1	OTHER CONDITIONS OF BRAIN

Public Comments

30-Jun-95

430	4.5	SUBARACHNOID HEMORRHAGE
431	8.5	INTRACEREBRAL HEMORRHAGE
437	1.1	OTHER AND ILL-DEFINED CEREBROVAS
852	5.1	SUBARACHNOID, SUBDURAL, AND EXTR
854	1.7	INTRACRANIAL INJURY OF OTHER AND

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61107							
AANS		090	000	4.47	4.35	0.97	4.35

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61107								
AANS	4.35	4.35	0.97	1.00	1.00	1.00	5.00	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61107								
AANS	000	4.47		20	*	31		31

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
61107									
AANS	*	0.5	*	10	1.0	*	10	0.0	1.2

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61107									
AANS	*	15		5.00	4.35	ns	3		0.077

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 61210 Global Period: 000 Current RVW: 4.72 Recommended RVW: 5.84

CPT Descriptor: Burr hole(s); for implanting ventricular catheter, reservoir, EEG electrode(s) or pressure recording device (separate procedure)

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended increase in RVW from 4.72 to 5.84.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year old man has a severe closed head injury with a Glasgow Coma Scale of 6 and no focal or lateralizing signs. Admitting CT scan shows no hematomas or shift but obliteration of the basal cisterns. Intracranial pressure monitoring with capability for drainage of ventricular fluid is desired. A frontal ventriculostomy catheter is implanted, and attached to an external monitoring and collection system.

Description of Pre-Service Work: includes review of imaging studies, review of past medical history and appropriate lab studies. Pre-service work includes informed consent with the family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup

Description of Intra-Service Work: A frontal scalp is made under local anesthesia. A twist drill hole is made, and a ventriculostomy catheter is introduced into the anterior horn of the lateral ventricle. The catheter is tunneled beneath the scalp for about 1-2 cm and then brought to the surface via a small stab wound. The catheter is connected to a pressure transducer and drainage tubing system. The system is calibrated to assure patency of the catheter. The scalp is then closed and dressings applied

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of leakage of ventricular fluid or infection. No post-operative services are included in the 000 Global period assigned.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61106	TWIST DRILL HOLE/IMPLANT VENT CATH WITH OTHER SURGERY	43	25		13	462		4.60	7.35	4.62
61105	TWIST DRILL HOLE/SUBDURAL OR VENTRIC.PUNCT	46	27		46	560		5.57	8.19	4.92
61107	TWIST DRILL HOLE/IMPLANT VENT.CATH OR RECORDING DEVICE	45	31		45	440		4.38	4.35	5.00
61210	BURR HOLE/VENTRICULAR CATHETER, RESERVOIR OR PRESSURE DEVICE	45	44		76	587		5.84	4.72	5.84
61151	BURR HOLE(S) FOR SERIAL ASPIRATION OF ABSCESS OR CYST	57	57		119	1158		11.53	11.40	
61154	BURR HOLE(S)/EVACUATION OF HEMATOMA, EXTRA- OR SUBDURAL, UNILAT.	65	69		176	1212	1361	12.06	13.67	

RELATIONSHIP OF 61210 TO REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The services in this family are scaled by their rank order valuation comparing each to their neighbors. Several are significantly over-valued and have been recommended for reductions. 61210 is one more step up in work than the reference service, 61107 (twist drill hole/implant vent cath or recording device), discussed above. The Harvard3 RVW is 5.84 and this appears appropriate in the context of the additional work of making a burr hole compared to a twist drill opening in the skull and implanting a reservoir beneath the scalp. This includes an intra-service time of 44 minutes compared to 31 minutes for 61107. The total work value reflects this difference appropriately, and the RVW of 5.84 represents an increase that retains the rank order within this family, compared to the undervalued RVW of 4.72 in the MFS95. We recommend a RVW of 5.84.

Code: 61210

RATIONALE for recommendation:

Work:
Changes in past 5 years:
Rank Order (Ordinal) Valuation: Rank order valuation is a basic tool to restore the appropriate relationships within this family of codes. The values listed in the table above reflects the face validity of these services and are supported by extrapolation from the Harvard3 time and work data.

Initial crosswalk or extrapolation misvaluation:
Prev. RUC or Refinement Valuation: Original RVW for 61210 from Phase I was 8.69 with a global of 090. When the global was changed to 000 in the May 1992 refinement, the RVW was reduced to 4.97 to account for the work

Time:
Op. Logs: Avg. intra- time = 41 min.
Anesthesia databases: Avg. anesthesia time = 85 min.
*AANS95 Survey: Survey data invalid due to respondents failing to adhere to global of 000, despite warnings, and include ICU visits, 7 hospital visits and 3 office visits.
Harvard3 Database: Time and work values appropriately higher than 61107.
Mental Effort & Judgement:
Technical Skill & Physical Effort: Slightly greater skill and effort for 61210 due to use of a burr hole as cranial access to ventricle.

Stress:
Intensity/Complexity: Complexity slightly greater than twist drill 61107 for same target.

Public Comments

30-Jun-95

Code: 61210

1995 RVUs: 4.72

Recommended RVUs: 5.84

Ratio:

Long Descriptor: Burr hole(s); for implanting ventricular catheter, reservoir, EEG electrode(s) or pressure recording device (separate procedure)

Reference Set (y/n): N **Global Period:** 000 **Frequency:** 1.865 **Impact:** 2089

Source: 17 **Year:** 93 **Public Comment Letter:** 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61210	42.6	3.7	15.1	50	14.8	1.9	0	7.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61210	2134	2014	-2.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61210	97.5	97.5	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61210	group practices	4.3
	neurological surgery	91.4
	neurology	2.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61210	191	1.4	MALIGNANT NEOPLASM OF BRAIN
	225	1.4	BENIGN NEOPLASM OF BRAIN AND OTH
	331	4.2	OTHER CEREBRAL DEGENERATIONS

Public Comments

30-Jun-95

430	1.9	SUBARACHNOID HEMORRHAGE
431	6.5	INTRACEREBRAL HEMORRHAGE
432	1.4	OTHER AND UNSPECIFIED INTRACRANI
852	3.7	SUBARACHNOID, SUBDURAL, AND EXTR
853	1.9	OTHER AND UNSPECIFIED INTRACRANI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61210							
AANS		090	000	5.96	4.72	0.79	4.72

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61210								
AANS	4.72	4.72	0.79	1.00	1.00	1.00	5.84	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61210								
AANS	000	5.96		20		44		27

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61210									
AANS		1.0	*	10	4.5		15	0.0	0.2

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61210									
AANS		15		5.84	4.72	ns	3		0.061

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Key Reference Procedure**

CPT Code: 61312 Global Period: 090 Current RVW: 20.50 Recommended RVW: 21.83

CPT Descriptor: **Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on Key Reference Procedure. AANS recommended increase in RVW from 20.50 to 21.83 based on AANS94 Survey data.**

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61154	BURR HOLES (EVACUATION OF HEMATOMA, EXTRA-OR SUBDURAL UNILATERAL)	65	69		176	1210	1361	12.06	13.67	
61312	CRANIOTOMY/EVAC. HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL	75	150		253	2040		20.30	20.54	
61312	CRANIOTOMY/EVAC. HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL	80	120	100	325		2194			21.83 AANS94
61510	CRANIOTOMY FOR EXCISION BRAIN TUMOR, SUPRATENT EXCEPT MENINGIOMA	91	213		194	2287	2454	23.17	23.39	26.77

RELATIONSHIP OF 61312 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61154 is a Key Reference for comparison, and is a simpler, less complex and shorter procedure than 61312 which involves a craniotomy for removal of a formed intracranial blood clot. Use of 61154 with burr holes implies a liquid collection of subdural blood, and consequently is done in a subacute to chronic stage contrasted to the acute circumstances that usually accompany the discovery of an acute sub- or epidural hematoma.

61312 is also a key reference procedure and was surveyed with values for work and time that resulted in a calculated total work value from the AANS survey of 2194 compared to the Harvard3 total work of 2040 for the same procedure. The intra-service time from the AANS survey was 120 minutes while that from Harvard3 was 150 minutes. The principal differences in total work came from the 28% greater amount of Pre- and especially Post-service time identified in the AANS94 survey, half of which derives from ICU time. When these time/work components are added to the intra-service work, the total exceeds the total work from Harvard3 upon which the existing RVW is based. The total AANS94 work value of 2194 converts to a RVW of 21.83 in the scale of the 1995 fee schedule

Another argument for increasing the RVW for 61312 is based on the evidence of what appeared to be an arbitrary compression of the total work value that was developed during the Harvard/Hsiao Phase II project. The total work value for 61312 delivered to HCFA was 2306, but the final work value after some unexplained adjustments at HCFA was only 2040. This represented an arbitrary reduction of 11.4%, which has remained unchanged since 1992.

12/2/10

Code: 61312

SURVEY DATA:

Specialty: Neurological Surgery

CPT 61312	Stats	LOS (Days)	PRE-SERVICE Time				INTRA TIME (Time)	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)				
			Hosp. Stay	Eval. before O.R.	Scrub and Dress	O.R. Entry to Skn Open		Skin Open to Skin Close	Skin Close to Reco very Room		ICU/CCU Visits	Other Hosptal Visits (NOT icu/ccu)	Dischg Day Mgmt.	Office Visits after discharge				
									O.R. Exit	Time				No. x	Time	SUM	No. x	Time	SUM	(Time)	No. x	Time	SUM
	min	4	5	5	5	30	5	0	1	10	10	2	10	20	10	1	10	10
	25th%	7	30	15	15	115	15	15	4	15	70	5	10	60	20	3	15	45
	median	12	45	15	20	120	15	20	6	20	100	8	15	105	25	4	15	60
	75th%	20	60	15	30	150	30	30	10	20	153	12	15	150	30	4	20	60
	max	24	150	35	230	255	45	120	20	60	600	34	90	810	75	10	45	210
Intra-time #:	100																	
Sample #:																		
% response:	48%																	

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Initial crosswalk or extrapolation misvaluation:

Ordinal comparisons to listed comparable services meet face validity.

The total work from Hsiao Phase II in 11/90 of 2306 was reduced at HCFA in 1991 to only 2039, an 11.4% reduction.

Time:

LOS:

Op. Logs:

LOS=12 days for AANS94 survey, and 12.1 days from HCIA94 data.

Intra time for Harvard3 =150 min. and for AANS94 =120 min. Two clinic op. logs =avg. intra time of 117 min.

Anesthesia databases:

AANS94 Survey Key Refs:

Harvard3 Database:

480 cases=avg. anesth.time of 218 min. Avg. intra time =137 min

Data used in recommendations.

Undervalued time for Post op office visits with 36 min. from Harvard3 compared to 60 min. from AANS94.

Undervalued time/Phase I or II & MFS92:

Note 100 min of ICU time in AANS94 survey not included in Harvard3 data

Mental Effort & Judgement:

Generally greater than 61154 due to decisions required to determine need for craniotomy rather than only burr holes, and related to the usual patient who has a solid clot rather than a collection of subdural fluid.

Technical Skill & Physical Effort:

Skill and effort greater for 61312.

Stress:

Higher acuity of illness in patients suitable for this service.

Intensity/Complexity:

Intensity and complexity significantly greater compared to 61154.

Public Comments

30-Jun-95

Code: 61312

1995 RVUs: 20.54

Recommended RVUs: 21.54

Ratio:

Long Descriptor: Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural

Reference Set (y/n): Y Global Period: 090 Frequency: 5,490 Impact: 5490

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61312	58.4	21.4	16.9	43.4	8.1	0	1.7	5.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61312	6341	6198	-1.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61312	98	98.9	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61312	group practices	2.5
	neurological surgery	94
	neurology	2.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61312	431	1.7	INTRACEREBRAL HEMORRHAGE
	432	10.5	OTHER AND UNSPECIFIED INTRACRANI
	852	9.7	SUBARACHNOID, SUBDURAL, AND EXTR
	853	1	OTHER AND UNSPECIFIED INTRACRANI

Public Comments30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61312							
AANS		090	090	20.71	20.54	0.99	20.54

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61312								
AANS	20.54	20.54	0.99	1.00	1.00	1.00	21.54	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61312								
AANS	090	20.71		42		150		58

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61312									
AANS		1.0		10	10.5		15	1.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61312									
AANS		15		21.54	20.54	ns	n		0.073

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

PT Code: 61313 Global Period: 090 Current RVW: 20.54 Recommended RVW: 22.63

PT Descriptor: **Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral**

Source and Summary of Comment to IICFA on this service:
AANS recommended increase in RVW from 20.54 to 22.63.

Public Comments by AANS.
Current AANS95 survey to validate time/work data.

CLINICAL DESCRIPTION OF SERVICE:

Signette Used in Survey: A 63 year old man has a spontaneous intracerebral hemorrhage into the basal ganglia in the minor hemisphere. He is hypertensive with normal clotting factors and no arrhythmia. Admitting CT scan shows a large hematoma or with shift and displacement of the medial temporal lobe into the incisura. He has a large sluggish pupil on that same side, suggesting early uncal herniation. A craniotomy is done with exposure and evacuation of the hematoma.

Description of Pre-Service Work: includes review of imaging studies, review of past medical history and appropriate lab studies. Pre-service work includes informed consent with the family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup.

Description of Intra-Service Work: A scalp flap is turned. One or two burr holes are placed and a bone flap elevated. The dura is opened while mannitol is administered. A tract through the cerebral tissue down to the hematoma is developed, and the clot removed. Hemostasis is accomplished and the retractors are removed. The dura is closed, frequently around a drain into the hematoma cavity. The bone flap is replace and secured, and the scalp reapproximated. The drain is connected to a sterile receptacle system. Dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of leakage of ventricular fluid, infection, or reaccumulation of the hematoma. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvt3	AANS	Hrvt3 to MFS95	MFS95	Rec New RVW
12	CRANIOTOMY/EVAC. HEMATOMA SUPRATENTORIAL EXTRASUBDURAL	130	150		837	2040		20.30	20.54	21.83
13	CRANIOTOMY/EVAC. HEMATOMA SUPRATENTORIAL INTRACEREBRAL	100	165		634	1862		18.53	20.54	
13	CRANIOTOMY/EVAC. HEMATOMA SUPRATENTORIAL INTRACEREBRAL	100	150		205	2293				22.63
14	CRANIOTOMY FOR EXCISION OF BRAIN ABSCESS, SUPRATENTORIAL	134	185		566	2293		23.44	23.49	

Code: 61313

RELATIONSHIP OF 61313 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61313 and 61312 are both rated at the same RVW of 20.54 in the MFS95. 61313 has a lower work value of 1862 in Harvard3 due to less Pre- and Post-service times. There is no allowance for ICU time/work in Harvard3 although almost all of these patients will spend time in ICU following surgery. The AANS95 Survey reports on average 90 minutes of ICU time for these patients which adds to the shorter post-service time and carries a higher intensity level.

Evaluation of other details of the service indicate this code is undervalued when compared to 61312 to which is similar in many respects. The evacuation of an intracerebral hematoma requires a cerebral incision, which is not part of 61312, and requires additional work in the form of extra time plus intensity factors which include increased judgemental decisions, some margin of technical skill in accurately encountering the hematoma, and the increased stress of entering the brain without stereotactic guidance. Since many of these procedures are done as emergency cases, the stress/risk factor is further increased. We recommend a survey RVW of 22.63.

This code 61313 is less total and intra-service time and approximately the same work as 61514 (CRANIOTOMY FOR EXCISION OF BRAIN ABSCESS, SUPRATENTORIAL) which has a RVW of 23.49 that closely approximates the Harvard3 total work as converted to the MFS95. This has face validity within the family of craniotomy codes and is not a contested value. It represents a more complex and intense service that shares many elements of 61313 in which the brain is entered for removal of an inflammatory abscess capsule rather than a hematoma.

SURVEY DATA:

Specialty: Neurological Surgery

61313	Stats	RVW	LOS (Days)	PRE-SERVICE Time		INTRA TIME		POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)				
				Hosp. Stay	Eval before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Skin Close	Sign to O.R.	Close Reco very Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Disch g Day Mgmt	Office Visits after discharge				
														No. x Time	SUM (Time)	No. x Time	SUM (Time)	No. x Time
min	15.00	2	15	10	5	75	10	0	2	3	6	0	0	0	10	1	10	10
25th%	21.63	8	30	15	20	120	15	10	5	15	75	5	10	50	20	2	15	30
median	22.00	10	60	15	25	150	20	20	6	15	90	6	15	90	30	3	15	45
75th%	23.39	14	60	15	35	180	30	30	9	20	180	6	15	120	30	4	20	60
max	27.00	21	180	30	60	240	60	90	20	40	80	26	20	520	75	6	30	90
rev n	275																	
N resp	54																	
%	20%																	

RATIONALE for recommendation:

Work: Rank Order (Ordinal) Valuation: Face valuation appropriate in table as listed.
 Initial crosswalk or extrapolation misvaluation: Initial valuation of 1862 which is low compared to 61312.

Op. Logs: Avg. time = 201 min.
 AANS95 Survey: 54 respondents support the time and work data in table above.
 Harvard3 Database:
 Undervalued time/Phase I or II & MFS92: Significant ICU time/work is delivered but was not included in the Harvard3 database.

Technical Effort & Judgement: Moderate increase due to invasion of brain tissue to accomplish approach with least damage.
 Technical Skill & Physical Effort: Greater than reference 61312 due to need to find and remove clot at depth in the cerebral tissue.
 Complexity: S1. higher than 61312
 Complexity greater for this service due to above factors.

Public Comments

30-Jun-95

Code: 61313 1995 RVUs: 20.54 Recommended RVUs: 22.50 Ratio:

Long Descriptor: Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral

Reference Set (y/n): N Global Period: 090 Frequency: 1,828 Impact: 3583

Source: 2 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

[Empty box for CMD Comment]

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61313	59.6	23.1	15.7	50	9.6	1.9	0	5.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61313	2392	2152	-5.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61313	98.5	98.6	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61313	group practices	4
	neurological surgery	92.5
	neurology	2.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61313	225	1.4	BENIGN NEOPLASM OF BRAIN AND OTH
	431	15.4	INTRACEREBRAL HEMORRHAGE
	432	1.4	OTHER AND UNSPECIFIED INTRACRANI
	852	2.9	SUBARACHNOID, SUBDURAL, AND EXTR

Public Comments

30-Jun-95

853	2.9	OTHER AND UNSPECIFIED INTRACRANI
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61313							
AANS		090	090	18.92	20.54	1.09	20.54

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
61313								
AANS	20.54	20.54	1.09	1.00	1.00	1.00	22.50	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61313								
AANS	090	18.92		42		165		58

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61313									
AANS		1.0		10	10.5		15	4.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61313									
AANS		15		22.50	20.54	ns	3		0.069

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on MisvaluedCode**

CPT Code: 61330 Global Period: 090 Current RVW: 15.65 Recommended RVW: 21.55

CPT Descriptor: **Decompression of orbit only, transcranial approach**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase RVW from 15.65 to 21.55.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61500	CRANIECTOMY/CRANIOTOMY FOR TUMOR OF SKULL	67	145		112	1707		16.99	16.93	
61334	EXPLORATION OF ORBIT WITH REMOVAL OF FOREIGN BODY	141	254		453	2232		22.22	17.07	
61304	CRANIECTOMY OR CRANIOTOMY, EXPLORATORY, SUPRATENT	76	161		165	2076		20.66	20.63	
61330	EXPLORATION OF ORBIT (TRANSCRANIAL) OR DECOMPRESSION, UNILATERAL	135	192		630	2165		21.55	15.65	21.55
61332	EXPLORATION OF ORBIT (TRANSCRANIAL) WITH BIOPSY	141	207		453	2444		24.33	26.08	
61333	EXPLORATION OF ORBIT WITH REMOVAL OF LESION	135	265		453	2696		26.83	26.75	

RELATIONSHIP OF 61330 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

This family of codes involving exploration of the orbit is arranged in rank order according to the work and intensity/complexity factors that apply. 61334 (EXPLORATION OF ORBIT WITH REMOVAL FOREIGN BODY) stands out of rank based on the high Harvard3 intra- and post-service times resulting in a higher work value of 2232 when compared to 61304 or 61330, both of which include a transcranial exploration rather than the simpler lateral approach of 61334. Therefore we believe that the times and work for 61334 are inflated and that the proportionately lower RVW from the current fee schedule is appropriate. The present code, 61330 (EXPLORATION OF ORBIT, TRANSCRANIAL, OR DECOMPRESSION, UNILATERAL) was properly valued by the Harvard3 data with a total work value of 2165, which translated to a RVW of 21.55 in terms of the current MFS. The lower value of 15.65 in the MFS95 is anomalous and is not supported by our analysis. We recommend a RVW of 21.55.

RATIONALE for recommendation:

Work:	The work of a transcranial exploration of the orbit is significantly greater than by anterior or lateral approaches.
Changes in past 5 years:	
Rank Order (Ordinal) Valuation:	Ordinal valuation of basic importance in this family.
Initial crosswalk or extrapolation misvaluation:	Suspect that lower RVW in MFS95 related to error in initial survey or extrapolation.
Prev. RUC or Refinement Valuation:	
Time:	
Harvard3 Database:	
Undervalued time/Phase I or II & MFS92:	Harvard3 valuation was appropriate but the RVW was reduced in MFS92 and subsequently.
Mental Effort & Judgement:	The effort & judgement in a transcranial approach is higher.
Technical Skill & Physical Effort:	Skill level slightly higher for 61330 compared to 61334
Stress:	Risk of complications higher with 61330 than 61334.
Intensity/Complexity:	Complexity higher for transcranial approach

Public Comments

30-Jun-95

Code: 61330

1995 RVUs: 15.65

Recommended RVUs: 21.55

Ratio:

Long Descriptor: Decompression of orbit only, transcranial approach

Reference Set (y/n): N

Global Period: 090

Frequency: 33

Impact: 195

Source: 1

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61330	50	0	0	100	50	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61330	38	40	3.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61330	89.3	90	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61330	neurological surgery	45
	ophthalmology	50
	plastic surgery	5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61330	242	25	THYROTOXICOSIS WITH OR WITHOUT G

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfewk95	Ratio5h	Mfewk92
61330							
AANS		090	090	22.00	15.65	0.71	15.65

Harvard Data:

Comm	Mswk93	Mfewk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61330								
AANS	15.65	15.65	0.71	1.00	1.00	1.00	21.55	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61330								
AANS	090	22.00		40	*	192		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuis	Offvis
61330									
AANS	*	1.0	*	10	11.0	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfewk95	Sp	Phase	Twput	Iwput
61330									
AANS	*	15		21.55	15.65	ns	3		0.074

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61340 Global Period: 090 Current RVW: 11.56 Recommended RVW: 17.33

CPT Descriptor: Other cranial decompression (eg, subtemporal), supratentorial

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended increase RVW from 11.56 to 17.33.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVW's		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Harv3	AANS	Harv3 to MFS95	MFS95	Rec.New RVW
61501	CRANIECTOMY FOR OSTEOMYELITIS OF SKULL	92	140		484	1806		17.98	13.59	
61550	CRANIECTOMY FOR CRANIOSTENOSIS, SINGLE SUTURE	113	108		224	1442		14.35	14.24	
61500	CRANIECTOMY/CRANIOTOMY FOR TUMOR OF SKULL	113	145		354	1707		16.99	16.93	
61340	OTHER CRANIAL DECOMPRESSION (SUBTEMPORAL), SUPRATENTORIAL, UNILATERAL	115	121		492	1741		17.33	11.56	17.33
61304	CRANIECTOMY OR CRANIOTOMY, EXPLORATORY, SUPRATENT	133	161		543	2076		20.66	20.63	

RELATIONSHIP OF 61340 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:
 No reference procedures will help position this code in the family. The first is 61500 (CRANIECTOMY FOR TUMOR OF SKULL) with a total work value of 1707, a time of 145 minutes and a current RVW of 16.93. This compares to 61340 total work of 1741 and time of 121 minutes with a current RVW of only 11.56. Since this RVW is low in comparison to the RVW of 61500 which has a total work value that is almost as high as that of 61340, we believe the RVW of 11.56 is out of appropriate rank order in this family.

The second reference service is 61304 (CRANIECTOMY, EXPLORATORY, SUPRATENTORIAL) which is equivalent in many aspects to 61340 and has a total work value of 2076, a time of 161 minutes and a RVW of 20.93.

Since 61340 has work and time intermediate between these two reference codes, we recommend the Harvard3 RVW of 17.33.

RATIONALE for recommendation:

<p>Work:</p> <p>Changes in past 5 years:</p> <p>Rank Order (Ordinal) Valuation:</p>	<p>The relative work units from Harvard3 support an increase in RVW to 17.33.</p> <p>Reduced use of this service due to advanced imaging techniques developed in past 5-10 years.</p> <p>A key element in establishing correction in the relativity to related procedures.</p>
<p>Intellectual Effort & Judgement:</p>	<p>Stepwise increase in all intensity components in this family of services.</p>
<p>Technical Skill & Physical Effort:</p>	<p>This service involves removal of a window of bone in the temporal region beneath the temporalis muscle. It is less demanding than 61304 but more than 61500.</p>
<p>Intensity/Complexity:</p>	<p>The complexity is close to that of 61304 since both services are used in patients with unclear diagnoses that require exploratory approaches to the intracranial space.</p>

Public Comments

Code: 61340	1995 RVUs: 11.56	Recommended RVUs: 17.33	Ratio:
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Long Descriptor: Other cranial decompression (eg, subtemporal), supratentorial

Reference Set (y/n):	N	Global Period:	090	Frequency:	53	Impact:	306
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Source:	1	Year:	92	Public Comment Letter:	340
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Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis – Beneficiary Information:

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
61340	62	58	-2.9

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61340	97.6	96.6	-0.5

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
61340	neurological surgery	93.1
	ophthalmology	3.4
	otolaryngology	3.4

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61340							
	AANS	090	090	17.67	11.56	0.65	11.56

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61340								
AANS	11.56	11.56	0.65	1.00	1.00	1.00	17.33	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61340								
AANS	090	17.67		35	*	121		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvvis	Offvis
61340									
AANS	*	1.0	*	10	8.0	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61340									
AANS	*	15		17.33	11.56	ns	3		0.095

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61470 Global Period: 090 Current RVW: 20.79 Recommended RVW: 24.60

CPT Descriptor: **Craniectomy, suboccipital; for medullary tractotomy**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 20.79 to 24.60.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61470	CRANIECTOMY, SUBOCCIPITAL, FOR MEDULLARY TRACTOTOMY	132	154		548	2472		24.60	20.79	24.60
61305	CRANIECTOMY OR CRANIOTOMY, EXPLORAT INFRATENTORIAL (POST FOSSA)	140	197		649	2486		24.74	24.77	
61480	CRANIECTOMY, SUBOCCIPITAL, FOR MESENCEPHALIC TRACTOTOMY/PEDUNCULOTOMY	132	151		548	2515		25.03	16.77	25.03

RELATIONSHIP OF 61470 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

These three procedures are related to pain management operations that require opening the posterior cranial fossa and introducing a probe into the substance of the brain stem in order to make a destructive lesion in a pain pathway. The risk factor alone in this procedure is very high due to the anatomy of the target structures and the plan to destroy a specific target area within the brain stem. The MFS95 work value of 61470 appears to be low when compared to the reference service 61305 (CRANIECTOMY FOR EXPLORATION, INFRATENTORIAL) with a total work value of 2486, an intra-service time of 197 minutes and a RVW of 24.77. These two procedures bridge the work and RVW of the reference procedure, supporting the rank order valuation depicted. Therefore, we recommend a RVW of 24.60 for 61470

RATIONALE for recommendation:

Work:	Rank Order (Ordinal) Valuation:	The rank order as listed is appropriate to these services.
Time:	Harvard3 Database:	The Harvard3 time and work data appear to be reliable in correcting this misvalued code.
Mental Effort & Judgement:		The mental effort and judgement in procedures that specifically create a destructive lesion within the brain stem are very high compared to other reference procedures.
Technical Skill & Physical Effort:		
Stress:		The stress and risk factors in this service are high.
Intensity/Complexity:		The complexity and intensity of the procedure are high, as reflected in the Harvard3 calculations of intensity as work/min. at 11.63, among the highest in the whole set of 61000 codes.

Public Comments

30-Jun-95

Code: 61470

1995 RVUs: 20.79

Recommended RVUs: 24.60

Ratio:

Long Descriptor: Craniectomy, suboccipital; for medullary tractotomy

Reference Set (y/n): N

Global Period: 090

Frequency: 9

Impact: 34

Source: 1

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61470	9	2	-52.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61470	88.9	100	5.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61470	group practices	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61470							
AANS		090	090	25.11	20.79	0.83	20.79

Harvard Data:

30-Jun-95

Public Comments

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
61470								
AANS	20.79	20.79	0.83	1.00	1.00	1.00	24.60	340

Harvard Data:

Comm	Peck95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61470								
AANS	090	25.11		40	*	154		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61470									
AANS	*	1.0	*	10	9.0	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61470									
AANS	*	15		24.60	20.79	ns	3		0.118

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61480 Global Period: 090 Current RVW: 16.77 Recommended RVW: 25.03

CPT Descriptor: **Craniectomy, suboccipital; for mesencephalic tractotomy or pedunculotomy**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 16.77 to 25.03.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61470	CRANIECTOMY, SUBOCCIPITAL, FOR MEDULLARY TRACTOTOMY	132	154		548	2472		24.60	20.79	24.60
61305	CRANIECTOMY OR CRANIOTOMY, EXPLORAT INFRATENTORIAL (POST FOSSA)	140	197		649	2486		24.74	24.77	
61480	CRANIECTOMY, SUBOCCIPITAL, FOR MESENCEPHALIC TRACTOTOMY/PEDUNCULOT	132	151		546	2515		25.03	16.77	25.03

RELATIONSHIP OF 61480 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

These two procedures (61480 and 61470) are related pain management operations that require opening the posterior fossa and introducing a probe into the substance of the brain stem in order to make a destructive lesion in a pain pathway. The risk factor alone in this service is very high, as reflected in the intensity numbers. However, the work valuation appears to be low when compared to the reference service 61305 (CRANIECTOMY FOR EXPLORATION, INFRATENTORIAL) with a total work value of 2486, an intra-service time of 197 minutes and a RVW of 24.77. These two procedures bridge the work and RVW of the reference procedure, supporting the rank order valuation depicted. Therefore, we recommend a RVW of 24.60 for 61470, and a RVW of 25.03 for 61480.

RATIONALE for recommendation:

Work:	Rank Order (Ordinal) Valuation:	The rank order as listed is appropriate to these services.
Time:	Harvard3 Database:	The Harvard3 time and work data appear reliable in correcting this misvalued code.
Mental Effort & Judgement:		The mental effort and judgement in procedures that specifically create a destructive lesion within the brain stem are very high compared to other reference procedures.
Technical Skill & Physical Effort:		Skill and effort both high in this type of procedure in area of brain stem and medulla.
Stress:		The stress and risk factors in this service are high.
Intensity/Complexity:		The complexity and intensity of the procedure are high, as reflected in the Harvard3 calculations of intensity as work/min. at 12.15. among the highest in the whole set of 61000 codes.

Public Comments

30-Jun-95

Code: 61480

1995 RVUs: 16.77

Recommended RVUs: 25.03

Ratio:

Long Descriptor: Craniectomy, suboccipital; for mesencephalic tractotomy or pedunculotomy

Reference Set (y/n): N Global Period: 090 Frequency: 0 Impact: 0

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61480	2	.	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61480	0	.	.

Trends Analysis -- Specialty Mix:

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61480							
AANS		090	090	25.55	16.77	0.66	16.77

Harvard Data:

Public Comments

30-Jun-95

Comm	Mawk93	Mfawk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61480								
AANS	16.77	16.77	0.66	1.00	1.00	1.00	25.03	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61480								
AANS	090	25.55		40	*	151		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61480									
AANS	*	1.0	*	10	9.0	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfawk95	Sp	Phase	Twput	Iwput
61480									
AANS	*	15		25.03	16.77	ns	3		0.123

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61490 Global Period: 090 Current RVW: 15.63 Recommended RVW: 24.20

CPT Descriptor: **Craniotomy for lobotomy, including cingulotomy**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 15.63 to 24.20.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61514	CRANIOTOMY FOR EXCISION OF BRAIN ABSCESS, SUPRATENTORIAL	137	191		639	2355		23.44	23.49	
61328	CRANIOTOMY/DRAINAGE OF INTRACRANIAL ABSCESS SUPRATENTORIAL	135	174		628	2402		23.91	23.90	
61490	CRANIOTOMY/LOBECTOMY, INCL. CINGULOTOMY, UNILAT.	135	167		556	2431		24.20	15.63	24.20
61510	CRANIOTOMY FOR EXCISION BRAIN TUMOR, SUPRATENT. EXCEPT MENINGIOMA	165	219		634	2328		23.17	23.39	26.77 AANS94

RELATIONSHIP OF 61490 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference service used for comparison is 61320 (CRANIOTOMY FOR DRAINAGE OF INTRACRANIAL ABSCESS, SUPRATENTORIAL) total work value of 2402, a time of 174 minutes and RVW of 23.90.

The total work value for 61490 is 2431, the time 167 minutes, and the recommended RVW 24.20, which fits well on the rank order scale within this family. The key reference 61510 (CRANIOTOMY FOR SUPRATENTORIAL BRAIN TUMOR) is of comparable complexity and work, with somewhat more time in all categories and a current MFS95 value of 23.39.

RATIONALE for recommendation:

Work:	Rank Order (Ordinal) Valuation:	Proper placement in rank order as listed above.
Time:	Harvard3 Database:	Harvard3 time and work data appear well valued.
	Undervalued time/Phase I or II & MFS92:	Significant undervaluation of total work despite Harvard3 data to support a higher RVW.
Mental Effort & Judgement:		Factors comparable to those of listed reference services.
Technical Skill & Physical Effort:		This service shares common technical and skill factors with 61510.
Stress:		
Intensity/Complexity:		The intensity of 61490 is comparable to that of both reference services.

Public Comments

30-Jun-95

Code: 61490

1995 RVUs: 15.63

Recommended RVUs: 24.20

Ratio:

Long Descriptor: Craniotomy for lobotomy, including cingulotomy

Reference Set (y/n): N

Global Period: 090

Frequency: 21

Impact: 180

Source: 1

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61490								

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61490	26	24	-3.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61490	92.3	100	3.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61490	group practices	16.7
	neurological surgery	83.3

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61490							
AANS		090	090	24.70	15.63	0.63	15.63

Public Comments

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61490								
AANS	15.63	15.63	0.63	1.00	1.00	1.00	24.20	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61490								
AANS	090	24.70		40	*	167		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61490									
AANS	*	1.0	*	10	9.0	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61490									
AANS	*	15		24.20	15.63	ns	3		0.106

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61510 Global Period: 090 Current RVW: 23.39 Recommended RVW: 26.77

CPT Descriptor: **Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on Key Reference Procedure. AANS recommended increase RVW from 23.39 to 26.77 based on AANS94 Survey data.**

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61154	BURR HOLES (EVACUATION OF HEMATOMA, EXTRA-OR SUBDURAL UNILATERAL	65	69		176	1210	1361	12.06	13.67	
61312	CRANIOTOMY/EVAC. HEMATOMA SUPRATENTORIAL, EXTRA/SUBDURAL	75	150		253	2040	2194	20.30	20.54	21.83
61320	CRANIOTOMY/DRAINAGE OF INTRACRANIAL ABSCESS SUPRATENTORIAL	77	174		190	2402		23.91	23.90	
61510	CRANIOTOMY FOR EXCISION BRAIN TUMOR, SUPRATENT. EXCEPT MENINGIOMA	91	213		194	2287		23.17	23.39	
61510	CRANIOTOMY FOR EXCISION BRAIN TUMOR, SUPRATENT. EXCEPT MENINGIOMA	105	200	50	235		2690			26.77 AANS94

RELATIONSHIP OF 61510 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61510 is a Key Reference procedure that has been undervalued due to the failure to appreciate the amount of post-operative time and work involved in this service. The Harvard3 data that was used to generate the original MFS92 RVWs did not allow for any ICU time, which runs at a higher intensity than other post-op time. It also underestimated the total amount of post-op time and work, as reflected in the table comparison of those values above. For example, the AANS94 survey identified an average of 50 minutes of ICU time and 235 minutes of other post-op services within the 90 day global period. This contributed to the AANS94 survey calculation of work of 2690 which exceeds the original Harvard3 total work calculation of 2287. This supports our argument to increase the RVW to 26.77 which represents the conversion of total work to the scale of the MFS95.

This also fits 61510 into a more satisfactory rank order valuation compared to 61320 (CRANIOTOMY FOR BRAIN ABSCESS) which is slightly less complex and has slightly less time and work than 61510. Two other common procedures, 61154 and 61312, are listed for general comparison to both time, work and RVWs.

Evidence of compression of the work of this code is present in the comparison of values for total work as delivered by Hsiao PhaseII in November 1990 to HCFA for incorporation into the Medicare Fee Schedule. The HsiaoII total work value delivered was 2846, which was reduced to 2322 by the time the cross specialty scale had been adopted at HCFA in June 1991. This was an 18.4% reduction without any reason offered as to the basis for the change. The RVW subsequently adopted was based on the lower work value, and was not approved for an increase when this problem was aired at the May 1992 Refinement Panel

We recommend that the RVW of 61510 be increased to 26.77 based on these considerations and comparisons that more accurately represent a correct value for the service.

Code: 61510

SURVEY DATA:		Specialty: Neurological Surgery																
CPT 61510	Stats	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
		Hosp. Stay	Eval. before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT ICU/CCU)	Dischg Day Mgmt.	Office Visits after discharge						
		(Days)	Time	Time	Time	(Time)	(Time)	(Time)	No. x Time	SUM	No. x Time	SUM	(Time)	No. x Time	SUM			
min		4	10	10	9	90	5	0	0	0	0	1	5	15	10	0	0	20
25th%		5	45	15	15	180	15	15	2	15	30	3	10	35	20	3	15	52
median		7	60	15	30	200	20	20	3	15	50	4	15	55	30	4	15	60
75th%		7	78	15	45	240	30	30	4	20	60	5	15	80	30	5	20	88
max		16	150	35	90	467	60	120	8	60	180	13	60	240	75	14	39	240
Intra-time #:		103																
Sample #:																		
% response:		49%																

RATIONALE for recommendation:

<p>Work:</p> <p>Rank Order (Ordinal) Valuation: Initial crosswalk or extrapolation misvaluation: Prev. RUC or Refinement Valuation:</p> <p>Time:</p> <p>LOS: Op. Logs: Anesthesia databases: AANS94 Survey Key Refs: Harvard3 Database: Undervalued time/Phase I or II & MFS92:</p> <p>Mental Effort & Judgement: Technical Skill & Physical Effort: Stress: Intensity/Complexity:</p>	<p>Work difference compared to Harvard3 calculation of total work that reflects greater post-op services than in original MFS. Ordinal valuation supports revision of 61510 RVW upward. Total work from Hsiao PhaseII in Nov. '90 was 2846. This was reduced to 2322 in the NPRM in 1991, an 18.4% reduction. 5/92 refinement panel held RVW at 24.65.</p> <p>AANS94 survey=7 days; HCIA94=8days. Avg. Intra-service times of 194 and 149 min. (131 cases) 257 cases; avg. time 277 min. Survey data supports increase in RVW Underestimated post-op and ICU time and work MFS92 did not incorporate increases acknowledged in Harvard4 to account for ICU time. More effort and judgement than 61320. Skill and effort usually greater than 61320. Stress level generally high for intracranial tumors. Complexity and intensity of tumor resection exceeds 61320.</p>
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Public Comments

30-Jun-95

Code: 61510

1995 RVUs: 23.39

Recommended RVUs: 24.42

Ratio:

Long Descriptor: Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma

Reference Set (y/n): Y Global Period: 090 Frequency: 4,768 Impact: 4911

Source: 4 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61510	34	2.1	7.8	53	8.4	0.7	0	15.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61510	5128	5123	0

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61510	98.1	99.1	0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61510	group practices	2.7
	neurological surgery	93.4
	neurology	2.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61510	191	13.3	MALIGNANT NEOPLASM OF BRAIN
	198	4.2	SECONDARY MALIGNANT NEOPLASM O
	225	2.1	BENIGN NEOPLASM OF BRAIN AND OTH

Public Comments

237	1.7	NEOPLASM OF UNCERTAIN BEHAVIOR O
239	3.3	NEOPLASMS OF UNSPECIFIED NATURE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61510							
AANS		090	090	23.65	23.39	0.99	23.39

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61510								
AANS	23.39	23.39	0.99	1.00	1.00	1.00	24.42	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61510								
AANS	090	23.65		52		219		62

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61510									
AANS		1.0		15	8.5		15	1.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61510									
AANS		15		24.42	23.39	ns	n		0.071

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61512 Global Period: 090 Current RVW: 24.26 Recommended RVW: 33.51

CPT Descriptor: **Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor; for excision of meningioma, supratentorial**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on Key Reference Procedure. AANS recommended increase in RVW from 24.26 to 33.51 based on AANS94 Survey data.**

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61370	CRANIOTOMY/DRAINAGE OF INTRACRANIAL ABSCESS SUPRATENTORIAL	77	174		190	2402		23.91	23.90	
61510	CRANIOTOMY FOR EXCISION BRAIN TUMOR, SUPRATENTORIAL EXCEPT MENINGIOMA	91	213		194	2287	2690	23.17	23.39	26.77
61512	CRANIOTOMY FOR EXCISION MENINGIOMA, SUPRATENTORIAL	83	241		183	2410		24.00	24.26	
61512	CRANIOTOMY FOR EXCISION MENINGIOMA, SUPRATENTORIAL	105	240	50	235		3368			33.51 AANS94

RELATIONSHIP OF 61512 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61512 was surveyed by AANS in Fall 1994 as part of the review of Key Reference Services in the specialty, with results as listed above in the last row of the table. Note that all of the time values exceed those as estimated in the Harvard3 project, with the result that the total work value for the procedure is depressed when compared to the AANS94 survey data as translated into a total work value. The survey intensity factor for 61512 was 9.63 compared to the same factor in Harvard3 of 6.91. This is a more realistic relationship among the intracranial tumor codes and reflects the responses of physicians who actually know the complexity and intensity of these procedures. When the AANS work value of 3368 is converted to the scale of the MFS95, the new RVW is 33.51, which is our recommended value. Also note that the major differences in time are in the post-op period, especially ICU time which amounts to 50 minutes compared to 0 minutes in Harvard3.

When 61512 is compared to the other services in the reference list, it falls in rank order well both in terms of total work units as well as RVWs when converted to the scale of the MFS95. The basis for a higher work value for 61512 is that surgery of an intracranial meningioma is generally more difficult and takes more time and work than resection of a glioma or abscess due to the attachment of the meningioma to dural structures that frequently contain a major dural venous sinus or are wrapped around an important artery or cranial nerve.

61512 (CRANIOTOMY FOR EXCISION MENINGIOMA, SUPRATENTORIAL) was assigned a total work value of 3122 in Harvard/Hsiao Phase II in 1991. This procedure was linked to the orthopedic procedure 27134 (REVISION, TOTAL HIP ARTHROPLASTY) in the cross-specialty linkage process in attempting to develop a common scale of relative values for all procedures. The common link between these two procedures was the intra-service time of 241 minutes for 61512 and 235 minutes for 27134. After the cross-specialty linkage and adjustments, the RVW for 61512 was 25.56 and the RVW for 27134 was 25.86. This analysis supports the argument that compression of the high valued procedures occurred during the Phase II to Phase III transition. The Harvard3 total work value of 2410 listed in the table above was the result of this compression since the original value was substantially higher before the linkage was imposed.

Code: 61512

SURVEY DATA:

Specialty: Neurological Surgery

CPT 61512	Stats	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global)		
			Hosp. Stay	Eval. before	Scrub and		O.R. Entry to	Skin Open to	Skin Close to	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day Mgmt.	Office Visits after discharge				
				O.R. Dress	Skin Open		Skin Close								O.R. Exit	No.x	Time	SUM
	min	3	10	10	9	110	5	0	0	0	0	2	5	20	10	0	0	20
	25th%	6	41	15	15	215	15	15	2	15	30	3	10	40	20	3	15	45
	median	7	60	15	30	240	20	20	3	15	50	4	15	60	25	3	15	50
	75th%	8	75	15	45	300	30	30	4	20	80	6	15	88	30	4	20	64
	max	16	180	35	120	480	115	120	10	30	240	15	45	225	75	33	40	495
	Intra-time #	103																
	Sample #																	
	% response	49%																

RATIONALE for recommendation:**Work:**

Work difference compared to Harvard3 calculation of total work that reflects greater post-op services than in original MFS.

Changes in past 5 years:**Rank Order (Ordinal) Valuation:**

Rank order valuation appropriate as listed in table.

Initial crosswalk or extrapolation misvaluation:

Hsiao PhaseII total work value of 2846 in 11/90 was reduced to 2408 at HCFA by 6/91, a 22.9% reduction.

Time:**LOS:**

AANS94 survey=7 days; HCIA94=8days.

Op. Logs:

Avg. Intra-service times of 212 min. (18 cases)

Anesthesia databases:

78 cases; avg. time 257 min.

AANS94 Survey Key Refs:

Survey data supports increase in RVW

Harvard3 Database:

Underestimated post-op and ICU time and work

Undervalued time/Phase I or II & MFS92:

MFS92 did not incorporate increases acknowledged in Harvard4 to account for ICU time.

Mental Effort & Judgement:

Planning and strategy for resection of a meningioma is generally more complex than for a glioma.

Technical Skill & Physical Effort:

Technical skill slightly greater than for 61510.

Stress:

Some higher stress levels in this service.

Intensity/Complexity:

Intensity and complexity frequently higher than 61510.

Public Comments

30-Jun-95

Code: 61512

1995 RVUs: 24.26

Recommended RVUs: 27.03

Ratio:

Long Descriptor: Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial

Reference Set (y/n): N Global Period: 090 Frequency: 2,331 Impact: 6457

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61512	37	1.5	21.4	71.1	11.9	0	0	7.5

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
61512	2699	2579	-2.2

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61512	98.6	98.8	0.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
61512	anesthesiology	2.3
	group practices	4.3
	neurological surgery	90.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61512	192	2.2	MALIGNANT NEOPLASM OF OTHER AND
	225	17.3	BENIGN NEOPLASM OF BRAIN AND OTH
	237	1.5	NEOPLASM OF UNCERTAIN BEHAVIOR O
	239	2.9	NEOPLASMS OF UNSPECIFIED NATURE

30-Jun-95

Public Comments

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61512							
AANS		090	090	24.48	24.26	0.99	24.26

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61512								
AANS	24.26	24.26	0.99	1.00	1.00	1.00	27.03	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61512								
AANS	090	24.48		47		241		67

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61512									
AANS		1.0		15	8.5		15	1.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61512									
AANS		15		27.03	24.26	ns	n		0.070

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61518 Global Period: 090 Current RVW: 32.27 Recommended RVW: 35.59

CPT Descriptor: **Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on Key Reference Procedure. AANS recommended an increase in RVW from 32.27 to 35.59 based on AANS94 Survey data.**

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61522	CRANIECTOMY FOR EXCISION OF BRAIN ABSCESS INFRATENTORIAL	82	220		205	2767		27.54	27.55	
61518	CRANIECTOMY/EXCISION TUMOR, INFRATENTORIAL, EXCEPT MENINGIOMA OR CPA TUMOR	104	299		241	3221		32.07	32.27	
61518	CRANIECTOMY/EXCISION TUMOR, INFRATENTORIAL, EXCEPT MENINGIOMA OR CPA TUMOR	110	240	60	250		3577			35.59 AANS94
61530	CRANIECTOMY FOR EXCISION CPA TUMOR/MID-POST FOSSA APPROACH	87	492		182	4134		41.15	42.35	

RELATIONSHIP OF 61518 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61518 was surveyed by AANS in Fall 1994 as part of the review of Key Reference Services in the specialty, with results as listed above in the third row of the table. Note that the only significant differences in time are in the 60 minutes of ICU time and the shorter time of 240 minutes for Intra-service time in the AANS94 survey. This Intra-service time has been corroborated from a number of operative logs and anesthesia databases (see below), with an average time of 245 minutes for this portion of the procedure. This conforms very closely to the median survey time of 240 minutes. The reason for a 59 minute difference compared to the earlier Harvard3 database of service times is not entirely clear, although use of some technical advances (the ultrasonic aspirating device for tumor resection) in the past few years may have reduced operative times by up to 15-20 minutes. We suspect the balance of the difference reflects overestimation by the original Harvard teams, especially of intra-operative time. Another difference is the 60 minutes of ICU time identified in the survey, which adds significantly to the total work of the service. Finally, the surveyed intensity factor of 10.19 reflects the degree of complexity and the intensity factors for this service that has a Harvard3 intensity of only 7.47. Allowing that the time data from the AANS94 survey are accurate and the intensity factor representative, the total work value calculated results in a RVW of 35.59.

61518 (CRANIECTOMY/EXCISION TUMOR, INFRATENTORIAL, EXCEPT MENINGIOMA OR CPA TUMOR) was assigned a total work value of 3829 in Harvard/Hsiao Phase II in 1991. This procedure was linked to the urologic procedure 51595 (Total cystectomy with ileal loop) in the cross-specialty linkage process in attempting to develop a common scale of relative values for all procedures. The common link between these two procedures was the intra-service time of 299 minutes for 61512 and 328 minutes for 51595. After the cross-specialty linkage and adjustments, the RVW for 61518 was 34.01 and the RVW for 51595 was 36.09. This analysis supports the argument that compression of the high valued procedures occurred during the Phase II to Phase III transition. The Harvard3 total work value of 3221 listed in the table above was the result of this compression since the original value was substantially higher before the linkage was imposed. This represented a 16% reduction in work value.

Code: 61518

SURVEY DATA:

Specialty: Neurological Surgery

CPT 61518	Stats	LOS (Days)	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
			Hosp Stay	Eval. before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day Mgmt.	Office Visits after discharge					
			(Time)	(Time)	(Time)	(Time)	(Time)	(Time)	No. x	Time	SUM	No. x	Time	SUM	(Time)	No. x	Time	SUM
	min	4	10	10	9	120	5	0	0	0	0	1	5	10	10	1	10	20
	25th%	6	45	15	20	210	15	15	2	15	30	4	10	40	20	3	15	52
	median	7	60	15	35	240	20	20	3	20	60	4	15	60	30	4	15	60
	75th%	8	90	15	60	300	30	30	4	20	100	6	15	90	30	4	20	90
	max	14	180	35	120	600	70	320	10	60	210	15	90	630	75	10	45	180
Intra-time #:	97																	
Sample #:																		
% response:	46%																	

RATIONALE for recommendation:

Work:

Changes in past 5 years:

Improvements in technology have facilitated deep tumor resection with some degree of time savings.

Rank Order (Ordinal) Valuation:

Rank order as expressed in table above is appropriate.

Initial crosswalk or extrapolation misvaluation:

The total work value from Hsiao/Harvard Phase II in 11/90 of 3829 was reduced to 3204 at HCFA by 6/91.

Time:

LOS:

AANS94 survey=7 days; HCIA94=8days.

Op. Logs:

Avg. Intra-service times of 245 min. (17 cases)

Anesthesia databases:

27 cases; avg. time 314 min.

AANS94 Survey Key Refs:

Survey data supports decrease in RVW

Harvard3 Database:

Underestimated ICU time and work

Undervalued time/Phase I or II & MFS92:

MFS92 did not incorporate increases acknowledged in Harvard4 to account for ICU time.

Mental Effort & Judgement:

The mental effort and judgment for this procedure in the posterior fossa is approx. the same as for 61512 and sl. less than 61520.

Technical Skill & Physical Effort:

The skill and effort are approx. the same as 61512 and sl. less than 61520.

Stress:

Stress is sl. greater than 61512.

Intensity/Complexity:

See above.

Public Comments

30-Jun-95

Code: 61518

1995 RVUs: 32.27

Recommended RVUs: 31.02

Ratio:

Long Descriptor: Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull

Reference Set (y/n): Y Global Period: 090 Frequency: 1,032 Impact: -1290

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61518	22.2	0	5.6	55.6	11.1	0	0	17.6

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
61518	1276	1117	-6.4

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61518	99.2	99.1	-0.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
61518	group practices	2.3
	neurological surgery	92.7
	neurology	2.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61518	191	8.3	MALIGNANT NEOPLASM OF BRAIN
	198	11.1	SECONDARY MALIGNANT NEOPLASM O
	225	6.9	BENIGN NEOPLASM OF BRAIN AND OTH

Public Comments

30-Jun-95

239	2.8	NEOPLASMS OF UNSPECIFIED NATURE
331	1.4	OTHER CEREBRAL DEGENERATIONS
759	1.4	OTHER AND UNSPECIFIED CONGENITAL
784	1.4	SYMPTOMS INVOLVING HEAD AND NEC
787	1.4	SYMPTOMS INVOLVING DIGESTIVE SYS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61518							
AANS		090	090	32.72	32.27	0.99	32.27

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61518								
AANS	32.27	32.27	0.99	1.00	1.00	1.00	31.02	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61518								
AANS	090	32.72		49		299		79

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
61518									
AANS		1.5		10	11.0		15	1.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61518									
AANS		15		31.02	32.27	ns	n		0.076

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61519 Global Period: 090 Current RVW: 33.84 Recommended RVW: 39.58

CPT Descriptor: **Craniectomy for excision of brain tumor, infratentorial or posterior fossa; meningioma**

Source and Summary of Comment to HCFA on this service:
AANS recommended increase in RVW from 33.84 to 39.58.

Public Comments by AANS.
Current AANS95 survey to validate time/work data.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 44 year old woman has a history of a headaches and dizziness. An MRI scan and angiogram show an enhancing and well vascularized tumor extending into the left cerebellum from the tentorium. A suboccipital craniectomy provides exposure of the cerebellum and the lesion is totally excised.

Description of Pre-Service Work: includes review of the angiogram and imaging studies, and appropriate lab and screening studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup. Positioning is lengthy due to the use of a semi-prone position and stabilization of the patient's head in a pin fixation device.

Description of Intra-Service Work: A paramedian suboccipital incision is made to divide the posterior cervical and suboccipital muscles. The suboccipital bone is exposed, retractors applied and a craniectomy is done after placement of one or several burr holes. The dura is opened and retracted, exposing the cerebellar cortex. The cerebellum is retracted to expose the surface of the meningioma which is attached to the under surface of the tentorium near the junction with the petrosal sinus. The margins are dissected away from the cerebellum with serial coagulation and division of the feeding vessels, including those coursing in the tentorium. The tumor is entered and debulked following which the capsule is excised piecemeal. The attachment to the tentorium requires resection of the tumor base attached to the tentorial dura. After complete excision of the lesion and confirmation of hemostasis, the dura is closed. The suboccipital and posterior cervical muscles and fascia and the scalp are closed in layers. A drain may be placed in the extradural space. Dressings are applied after the patient is removed from the fixation device and turned supine.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of intracranial bleeding or spinal fluid leakage. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec.New RVW
61522	CRANIECTOMY/EXCISION OF BRAIN ABSCESS, INFRATENTORIAL	82	220		205	2767		27.54	27.55	
61518	CRANIECTOMY/EXCIS TUMOR, INFRATENT. EXC MENINGIOMA OR CPA TUMOR	104	299		241	3221	3577	32.07	32.27	35.59 AANS94
61519	CRANIECTOMY/EXCISION OF MENINGIOMA, INFRATENTORIAL	177	354		653	3417		34.01	33.84	
61519	CRANIECTOMY/EXCISION OF MENINGIOMA, INFRATENTORIAL	120	300	53	180		3978			39.58 AANS95
61530	CRANIECTOMY/EXCISION CPA TUMOR/MID-POST FOSSA APPROACH	156	492		600	4134		41.15	42.35	
61526	CRANIECTOMY/EXCISION OF CPA TUMOR, MASTOID APPROACH	177	319		546	3459	5084	34.43	29.71	50.59 AANS94
61520	CRANIECTOMY/EXCISION CEREBELLOPONTINE ANGLE TUMOR	175	374		602	3876	5325	38.58	38.85	52.98 AANS94

Code: 61519

RELATIONSHIP OF 61519 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61519 has not been surveyed since the original Harvard studies and the time data in the table above represents that data. One significant omission is the lack of any ICU time, which is almost always a part of this service. This amounts to 53 minutes in the current survey data. Also note the short post-service time from the survey of only 180 minutes after ICU which probably represents the use of newer technologies for tumor resection that reduce dissection time.

Comparison of 61519 to listed reference services shows an appropriate rank order among the procedures in the table. The results of the AANS95 survey included use of surveyed intensity and complexity factors. Comparison of the work per minute from the Harvard3 of 7.31 units to the AANS95 of 9.54 reflects a more realistic scaling of the intensity for this complicated service.

61530 is a helpful reference service since it shares the some of the same techniques in approach and dissection as 61519 and both are done in the posterior fossa. The complexity of both are comparable while the total time and intra-service time are less for 61519.

Our recommendation is to accept the survey RVW of 39.58.

Specialty: Neurological Surgery

CPT 61519	Stats	RVW	LOS (Days)	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS							OFFICE VISITS (thru glob				
				Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close		ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day Mgmt.	Office Visits				
										O.R. Exit	Reco very Room				No. x Time	SUM	No. x Time	SU	
min	23.39	5	10	10	5	150	15	0	0	0	0	2	7	14	10	1	5	5	
25th%	35.00	6	45	15	25	240	20	15	3	14	42	4	10	40	20	2	15	30	
median	37.00	7	60	15	45	300	25	20	4	15	60	4	15	60	30	3	15	45	
75th%	38.50	7	80	15	60	360	30	30	5	20	100	6	15	90	30	4	20	60	
max	50.00	15	180	30	90	480	60	120	15	40	600	10	30	300	75	6	30	18	
survey n	275																		
RVW resp	53																		
rate %	19%																		

RATIONALE for recommendation:

Work:
 Changes in past 5 years: Some changes in technology permitting more rapid dissection.
 Rank Order (Ordinal) Valuation: Rank order as expressed in table above is appropriate.
 Initial crosswalk or extrapolation misvaluation: Implicit compression of work values for high valued procedures based on example described re: 61512.
 Prev. RUC or Refinement Valuation:

Time:
 Op. Logs: Avg. Intra-service times of 195 min. (10 cases)
 Anesthesia databases: Avg. anesthesia time of 328 min. (48 cases)
 AANS94 Survey Key Refs: Procedure surveyed for this review.
 Undervalued time/Phase I or II & MFS92: Lack of ICU time in Harvard3 database for this service.
 Mental Effort & Judgement: See above for comparative analysis.
 Technical Skill & Physical Effort:
 Stress:
 Intensity/Complexity:

Public Comments

30-Jun-95

Code: 61519

1995 RVUs: 33.84

Recommended RVUs: 39.98

Ratio:

Long Descriptor: Craniectomy for excision of brain tumor, infratentorial or posterior fossa; meningioma

Reference Set (y/n): N

Global Period: 090

Frequency: 1,025

Impact: 6294

Source: 1

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61519	21.4	0	7.1	78.6	7.1	0	0	7.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61519	650	1619	57.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61519	98.3	99.6	0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61519	anesthesiology	67.6
	neurological surgery	29.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61519	191	1.8	MALIGNANT NEOPLASM OF BRAIN
	225	16.1	BENIGN NEOPLASM OF BRAIN AND OTH
	238	1.8	NEOPLASM OF UNCERTAIN BEHAVIOR O
	239	1.8	NEOPLASMS OF UNSPECIFIED NATURE
	331	3.6	OTHER CEREBRAL DEGENERATIONS

30-Jun-95

Public Comments

336	1.8	OTHER DISEASES OF SPINAL CORD
348	1.8	OTHER CONDITIONS OF BRAIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61519							
AANS		090	090	34.70	33.84	0.98	33.84

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61519								
AANS	33.84	33.84	0.98	1.00	1.00	1.00	39.98	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61519								
AANS	090	34.70		51		354		80

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61519									
AANS		1.5		15	10.0		15	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	-Sp	Phase	Twput	Iwput
61519									
AANS		15		39.98	33.84	ns	3		0.074

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61520 Global Period: 090 Current RVW: 38.35 Recommended RVW: 52.98

CPT Descriptor: **Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 38.35 to 52.98 based on AANS94 survey data.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec. New RVW	Hrvd3 Wrk/mln AANS94
61510	CRANIOTOMY FOR EXCISION BRAIN TUMOR, SUPRATENT, EXCEPT MENINGIOMA	165	219		634	2328	2690	23.17	23.39	26.77	6.98 8.16
61512	CRANIOTOMY FOR EXCISION MENINGIOMA, SUPRATENTORIAL	149	241		596	2411	3368	24.00	24.26	33.51	6.91 9.63
61518	CRANIECTOMY/EXCIS TUMOR, INFRATENT EXC MENINGIOMA OR CPA TUMOR	192	299		795	3222	3577	32.07	32.27	35.59	7.47 10.19
61526	CRANIECTOMY/EXCISION OF CPA TUMOR, MASTOID APPROACH	177	319		546	3459	5084	34.43	29.71	50.59	8.57 11.33
61530	CRANIECTOMY/EXCISION CPA TUMOR/MID-POST FOSSA APPROACH	156	492		600	4134		41.15	42.35		6.87
61520	CRANIECTOMY/EXCISION OF CEREBELLOPONTINE ANGLE	96	374		183	3878		38.58	38.35		8.29
61520	CRANIECTOMY/EXCISION OF CEREBELLOPONTINE ANGLE	120	360	60	250		5325			52.98 AANS94	11.59 AANS94

RELATIONSHIP OF 61520 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61520 was surveyed by AANS in Fall 1994 with results as listed in the last row of the table above. Note the principal differences are in the post-operative time period, including 60 minutes of ICU service and additional 67 minutes of post-op time after ICU. These add up to an increase in total work from the Harvard3 sum of 3878 to the AANS94 sum of 5325, which translates into a RVW of 52.98 for the MFS95. In addition, the Harvard3 intensity factor for 61520 is 8.29 while the survey factor is 11.59 which more accurately reflects the combination of intensity factors that are present in surgery in the cerebellopontine angle where the pons and cranial nerves are involved in the tumor dissection for extended periods of time. The skill and stress levels in this surgery are comparable to those in dealing with an aneurysm that is located on a major vessel to the dominant hemisphere. Comparison to 61526 and 61530 places 61520 in an appropriate relative position compared to the other procedures listed of similar nature.

Comparison to reference service shows greater times for the various components of the service and an equal total work value. The RVW for 61530 of 42.35 was assigned by HCFA in 1994 and is probably undervalued, although we have no current survey data to apply to this code.

Code: 61520

SURVEY DATA:

Specialty: Neurological Surgery

CPT 61520	Stats	LOS (Days)	PRE-SERVICE Time			INTRA TIME (Time)	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
			Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Reco very Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day Mgmt	Office Visits after discharge				
			(Time)	(Time)	(Time)	(Time)	(Time)	(Time)	No.x	Time	SUM	No. x	Time	SUM	(Time)	No. x	Time	SUM
	min	5	10	10	9	180	5	0	1	10	10	2	5	20	10	0	0	20
	25th%	6	43	15	30	300	15	15	2	15	40	4	10	40	20	3	15	46
	median	7	60	15	45	360	25	20	4	17	60	4	15	60	25	4	15	60
	75th%	9	90	15	60	480	30	30	5	20	93	6	15	90	30	4	20	80
	max	14	150	35	120	720	60	180	10	30	210	16	90	720	75	10	39	240
Intra-time #:	100																	
Sample #:																		
% response:	48%																	

RATIONALE for recommendation:

Work: Total work as surveyed exceeds that as estimated by Harvard3 and provided for the MFS92, with a resultant increase in the RVW.

Rank Order (Ordinal) Valuation: Appropriate for this set of procedures as listed.

Initial crosswalk or extrapolation misvaluation: Implicit compression of work values for high valued procedures based on example described re: 61512

Time:

LOS: AANS94 survey=7 days; HCIA94=8days.

Op. Logs: Avg. Intra-service times of 352 min. (6 cases)

Anesthesia databases: 245 cases; avg. time 354 min.

AANS94 Survey Key Refs: 100 neurosurgeons responded to survey

Harvard3 Database: Underestimated ICU time and work

Undervalued time/Phase I or II & MFS92: MFS92 did not incorporate increases acknowledged in Harvard4 to account for ICU time.

Mental Effort & Judgement: Mental effort and judgement comparable to 61530.

Technical Skill & Physical Effort: Technical skill greater than 61530.

Stress: Stress slightly higher since most of the cases in 61520 represent patients with larger tumors than those approached by the approach covered in 61530.

Intensity/Complexity: Complexity sl. higher than reference services in this class of tumor.

Public Comments

30-Jun-95

Code: 61520

1995 RVUs: 38.35

Recommended RVUs: 41.16

Ratio:

Long Descriptor: Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor

Reference Set (y/n): Y Global Period: 090 Frequency: 424 Impact: 1191

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61520	48	24	0	68	8	0	0	16

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
61520	565	493	-6.6

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61520	96.6	98.2	0.8

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
61520	anesthesiology	6.5
	group practices	3.9
	neurological surgery	67.9
	neurology	2
	otolaryngology	19.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61520	198	1.9	SECONDARY MALIGNANT NEOPLASM O
	215	1.9	OTHER BENIGN NEOPLASM OF CONNEX

Public Comments

30-Jun-95

225	17.3	BENIGN NEOPLASM OF BRAIN AND OTH
228	1.9	HEMANGIOMA AND LYMPHANGIOMA, A
237	1.9	NEOPLASM OF UNCERTAIN BEHAVIOR O
239	1.9	NEOPLASMS OF UNSPECIFIED NATURE
250	1.9	DIABETES MELLITUS
344	1.9	OTHER PARALYTIC SYNDROMES

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61520							
AANS		090	090	39.37	38.35	0.97	38.35

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61520								
AANS	38.35	38.35	0.97	1.00	1.00	1.00	41.16	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61520								
AANS	090	39.37		50		374		81

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61520									
AANS		1.5		15	9.0		15	1.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61520									
AANS		15		41.16	38.35	ns	3		0.084

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61521 Global Period: 090 Current RVW: 39.48 Recommended RVW: 42.20

CPT Descriptor: **Craniectomy for excision of brain tumor, infratentorial or posterior fossa; midline tumor at base of skull**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 39.48 to 42.20.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61597	TRANSCONDYLAR APPROACH TO POST FOSSA, JUG. FORAMEN OR MIDLINE SKULL BASE, INCLUDE OCCIP CONDYLECTOMY, MASTOIDECTOMY	191	368		403				36.12	
61616	RESECTION OF NEOPLASTIC, VASC OR INFECT LESION BASE OF POST FOSSA, JUG FORAMEN OR C1-3 VERT BODIES, EXTRADURAL	136	215		400				41.29	
61521	CRANIECTOMY/EXCISION OF MIDLINE TUMOR @ BASE OF SKULL	98	411		247	3958		39.39	39.48	42.20
61530	CRANIECTOMY/EXCISION CPA TUMOR/MID-POST FOSSA APPROACH	87	492		182	4134		41.15	42.35	
61526	CRANIECTOMY/EXCISION OF CPA TUMOR, MASTOID APPROACH	96	319		166	3459	5084	34.43	29.71	50.59
61520	CRANIECTOMY/EXCISION CEREBELLOPONTINE ANGLE TUMOR	96	374		183	3876	5325	38.58	38.35	52.98

RELATIONSHIP OF 61521 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:
61521 (CRANIECTOMY FOR EXCISION OF A MIDLINE TUMOR AT THE BASE OF THE SKULL) represents a very complex surgical procedure applied to a difficult to reach area surrounded by delicate and important structures. It is quite similar to 61530 (CRANIECTOMY FOR EXCISION OF A CPA TUMOR BY A COMBINED MIDDLE AND POSTERIOR FOSSA APPROACH) in the difficulty, dangers and amount of work that comprises the service. Also note that the combination of 61597 and 61616 as skull base procedures effectively can be used in place of 61521, with a summation of their RVWs, even with a multiple procedure 50 % reduction for the second procedure, to about 56 RVWs.

The underestimation of the total work of this group of complex procedures has fallen to the same oversight noted for other major intracranial services, i.e., the failure of the original Harvard team to include adequate post-operative time and work and the failure to account for sufficient time and work in the ICU for most of these patients. The AANS94 survey showed an average of 39% underestimation of post-service time and work for the high valued and more complex procedures when compared to the Harvard3 database.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Rank order valuation appropriate as listed in table.

Initial crosswalk or extrapolation misvaluation:

Implicit compression of work values for high valued procedures based on example described re: 61512.

Time:

Undervalued time/Phase I or II & MFS92:

MFS92 did not incorporate increases acknowledged in Harvard4 to account for ICU time.

Mental Effort & Judgement:

High levels of decision making

Technical Skill & Physical Effort:

Technical skill substantially greater than for 61510.

Stress:

High stress and risk levels due to contents of target area

Intensity/Complexity:

Very high intensity & complexity compared to 61510.

Public Comments

Code: 61521

1995 RVUs: 39.48

Recommended RVUs: 42.20

Ratio:

Long Descriptor: Craniectomy for excision of brain tumor, infratentorial or posterior fossa; midline tumor at base of skull

Reference Set (y/n): N Global Period: 090 Frequency: 105 Impact: 286

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61521	50	0	0	50	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61521	170	119	-16.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61521	99.4	100	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61521	group practices	2.5
	neurological surgery	80.7
	neurology	6.7
	otolaryngology	6.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61521	225	12.5	BENIGN NEOPLASM OF BRAIN AND OTH
	348	25	OTHER CONDITIONS OF BRAIN

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61521							
AANS		090	090	40.19	39.48	0.98	39.48

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61521								
AANS	39.48	39.48	0.98	1.00	1.00	1.00	42.20	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61521								
AANS	090	40.19		55	*	411		85

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61521									
AANS	*	1.5	*	10	14.5	*	10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61521									
AANS	*	15		42.20	39.48	ns	3		0.073

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 61526 Global Period: 090 Current RVW: 29.71 Recommended RVW: 50.59

CPT Descriptor: **Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on Key Reference Procedure. AANS recommended increase in RVW from 29.71 to 50.59 based on AANS94 survey data. Current survey proposed by AAO-HNS.**

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	Hrvd3 Wrk/min AANS94
61510	CRANIOTOMY FOR EXCISION BRAIN TUMOR, SUPRATENT, EXCEPT MENINGIOMA	165	219		634	2328	2690	23.17	23.39	26.77	6.98 8.16
61512	CRANIOTOMY FOR EXCISION MENINGIOMA, SUPRATENTORIAL	149	241		596	2411	3368	24.00	24.26	33.51	6.91 9.63
61518	CRANIECTOMY/EXCIS TUMOR, INFRATENT, EXC.MENINGIOMA OR CPA TUMOR	192	299		795	3222	3577	32.07	32.27	35.59	7.47 10.19
61526	CRANIECTOMY/EXCISION OF CPA TUMOR, MASTOID APPROACH	177	319		546	3459		34.43	29.71		8.57
61526	CRANIECTOMY/EXCISION OF CPA TUMOR, MASTOID APPROACH	100	360	45	225		5084			50.59 AANS94	11.33 AANS94
61526	CRANIECTOMY/EXCISION OF CEREBELLOPONTINE ANGLE	96	374		183	3878	5325	38.58	38.35	52.98	8.29 11.59 AANS94

RELATIONSHIP OF 61526 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61526 was surveyed by AANS in Fall 1994 as part of the review of Key Reference Services in the specialty, with results as listed above in fifth row of the table. The significant differences between the Harvard3 data and the AANS94 survey data are in the greater Intra-service time for the AANS94 survey plus the 45 minutes of ICU time not included in the Harvard3 database. The net result of these changes was to increase the total work value from 3459 to 5084, which translates to a current RVW of 50.59, which is our recommendation. This fits well in rank order with allied procedures, including comparisons of total work.

SURVEY DATA:

Specialty: **Neurological Surgery**

CPT 61526	Stats	LOS (Days)	PRE-SERVICE Time			INTRA TIME (Time)	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
			Hosp. before Stay	Eval. O.R. Dress	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	to Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day Mgmt.	Office Visits after discharge				
	min	3	10	10	10	180	10	0	0	0	0	2	5	20	10	1	10	20
	25th%	5	30	15	30	300	15	10	2	15	30	3	10	30	20	2	15	45
	median	7	45	15	40	360	20	20	3	15	45	4	15	60	20	3	15	60
	75th%	7	60	15	60	420	30	30	4	20	60	6	15	90	30	4	30	80
	max	10	150	35	120	720	60	180	6	30	150	14	90	720	60	8	30	240

Intra-time #: _____

nse: _____

CPT Code 61526

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Rank order valuation appropriate as listed in table.

Initial crosswalk or extrapolation misvaluation:

Implicit compression of work values for high valued procedures based on example described re: 61512.

Prev. RUC or Refinement Valuation:

5/92 refinement panel retained value of 31.31

Time:

LOS:

AANS94 survey=7 days; HCIA94=8days.

Op. Logs:

Avg. Intra-service times of 394 min. (5 cases)

Anesthesia databases:

AANS94 Survey Key Refs:

Survey data supports increase in RVW

Harvard3 Database:

Underestimated intra-service time and ICU time and work MFS92 did not incorporate increases acknowledged in Harvard4 to account for ICU time.

Undervalued time/Phase I or II & MFS92:

Extra effort and judgment required.

Mental Effort & Judgment:

Technical Skill & Physical Effort:

Technical skill substantially greater than for 61510.

Stress:

High stress and risk levels due to contents of target area

Intensity/Complexity:

Very high intensity & complexity compared to 61510.

Public Comments

30-Jun-95

Code: 61526

1995 RVUs: 29.71

Recommended RVUs: 45.00

Ratio:

Long Descriptor: Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor,

Reference Set (y/n): Y

Global Period: 090

Frequency: 150

Impact: 2294

Source: 4

Year: 93

Public Comment Letter: 338

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO-HNS

Societies Wishing to Comment: AANS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61526	20	0	0	40	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61526	263	172	-19.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61526	94.7	94.8	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61526	neurological surgery	43
	otolaryngology	53.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61526	191	5	MALIGNANT NEOPLASM OF BRAIN
	225	20	BENIGN NEOPLASM OF BRAIN AND OTH

Harvard Data:

30-Jun-95

Public Comments

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61526							
AANS		090	090	35.13	29.71	0.85	29.71
AAOHNS		090	090	35.13	29.71	0.85	29.71

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61526								
AANS	29.71	29.71	0.85	1.00	1.00	1.00	40.71	340
AAOHNS	29.71	29.71	0.85	1.00	1.00	1.00	45.00	338

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61526								
AANS	090	35.13		49		319		70
AAOHNS	090	35.13		49		319		70

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61526									
AANS		1.5		15	9.0		10	0.0	2.5
AAOHNS		1.5		15	9.0		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61526									
AANS		15		40.71	29.71	xx	n		0.087
AAOHNS		15		45.00	29.71	xx	n		0.087

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 61531 Global Period: 090 Current RVW: 20.50 Recommended RVW: 12.95

CPT Descriptor: Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended decrease in RVW from 20.50 to 12.95. Current AANS95 survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 24-year-old male presents with intractable seizures. He has had extensive EEG monitoring without identification of a convincing seizure focus. One or several burr holes are drilled, and after opening the dura, strip electrodes are slid into the subdural space over the cortex to cover the area under investigation. The electrodes are brought out through the incisions to allow connection to monitoring equipment.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec.New RVW	Hrwd3 Wrk/mjn
61855	TWIST DRILL OR BURR HOLE/IMPLANT SUBCORTICAL ELECTRODES	58	75		107	942		9.38	12.94	10.00	6.65
61531	SUBDURAL IMPLANT STRIP ELECTRODES VIA BURR HOLE(S)/SEIZURE MONITORING								20.50		
61531	SUBDURAL IMPLANT STRIP ELECTRODES VIA BURR HOLE(S)/SEIZURE MONITORING	150	90	15	294		1302			12.95 AANS95	3.50 AANS95
61154	BURR HOLES (EVACUATION OF HEMATOMA EXTRA- OR SUBDURAL UNILATERAL)	65	69		176	1210	1361	12.06	13.67		7.61
61534	CRANIOTOMY/EXCISION EPILEPTOGENIC FOCUS W/O EEG	80	199		197	2478		21.77	19.13		8.48
61312	CRANIOTOMY/EVAC HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL	75	150		253	2040		20.30	20.54	21.83 AANS94	7.15

RELATIONSHIP OF 61531 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61531 has not been surveyed previously or valued by either Harvard3 or AANS. The original RVW of 19.26 was recommended after presentation by the AAN to the RUC in June 1992 and was forwarded to HCFA that Fall. HCFA increased the RVW because they felt that the proportional relationship between the reference service 61154 (BURR HOLES (EVACUATION OF HEMATOMA EXTRA- OR SUBDURAL UNILATERAL) and 61531 of 1.5X was appropriate. They applied that multiplier to the value of 61154 which by then had increased to 14.40. The final RVW accepted for the MFS following these adjustments was 1.5 x 14.40 = 21.60. This has since declined to 20.50 due to the budgetary adjustments imposed since 1992.

We believe that the comparisons of the components of intensity between 61531 and 61154 will help to support the relationship of RVWs proposed. The mental effort and judgment involved in 61531 is relatively complicated since it involves selecting the proper areas of the brain to cover with the electrode monitoring strips and correlating the non-invasive EEG data to the other clinical and anatomic information to make a proper location selection. However, the mental effort and judgment in burr holes for evacuation of a subdural, while much easier since the advent of good imaging technology, still requires some complex judgments regarding the best approach, the timing of the procedure, and the other factors of co-morbidity that may influence the how and when of surgery.

The technical skill is roughly comparable with the addition that some extra skill may be required in irrigation of blood clots from the subdural space in areas somewhat remote from the burr hole opening in the skull.

The risk/stress factors are clearly higher in 61154 where the acuity of illness and responses raise the level substantially.

The present recommended value of 12.95 for the RVW is based on rank order valuation within the series of related procedures listed coupled with survey data that indicates a lower amount of work than originally proposed.

Code: 61531

The AANS95 survey had only 3 responses to this service due in part to the very low frequency of the procedure, and the times are listed in the table. However, the times appear reasonable and the total work calculated is very close to that of the reference service 61154. Since the survey intensity is only 3.50 compared to the Harvard3 intensity of 7.00, the final RVW is only 12.95.

Finally, a high end comparison to 61534 (CRANIECTOMY/EXCISION EPILEPTOGENIC FOCUS W/O EEG) which opens the skull and involves resection of areas of cerebral tissue identified as containing epileptogenic foci is offered. This service is clearly more time, work and intensity than 61531 to which it is currently rather closely matched, with MFS95 RVWs of 21.77 and 20.50 respectively. This further supports the impression of over-valuation of 61531 and supports the reduction recommended.

SURVEY DATA:

Specialty: Neurological Surgery

		LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)						
		Hosp Stay	Eval before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Reco very Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day Mgmt.	Office Visits after discharge							
61531	Stats	RVW	Days	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM	
	min	15.00	5	40	10	25	60	15	15	0	0	0	7	5	35	20	1	15	15
	25th%	15.00	6	65	13	35	75	18	15	1	8	4	8	8	56	20	2	18	26
	median	15.00	7	80	16	45	90	20	15	1	15	15	8	18	80	20	2	20	40
	75th%	15.13	11	105	15	53	120	25	18	2	15	23	11	13	131	20	2	23	45
	max	15.25	14	120	15	60	150	30	20	2	15	30	13	15	195	20	2	25	50
survey n		275																	
RVW resp		3																	
rate %		1%																	

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

The rank order valuation listed in the table of reference services is reasonable comparing the components of the services listed.

Prev. RUC or Refinement Valuation :

The RUC recommended a RVW of 19.26 in 1992. HCFA increased the RV to 21.60 by reference to 61154 @ a RVW of 12.54 and increased 61531 by 1 times 61154. When 61154 was raised in refinement to 14.4, the 1.5 times factor resulted in a final RVW for 61531 of 21.60.

Time:

AANS95 Survey :

Time and work data less than 2050 support current RVW of 12.95.

Harvard3 Database:

No data available

Mental Effort & Judgement:

See above for comparisons.

Technical Skill & Physical Effort:

Stress:

Intensity/Complexity:

Public Comments

Code: 61531

1995 RVUs: 20.5

Recommended RVUs: 23.33

Ratio:

Long Descriptor: Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring

Reference Set (y/n): N Global Period: 090 Frequency: 42 Impact: 119

Source: 9 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61531	0	0	0	50	100	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61531		56	

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61531		92.9	

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61531	group practices	28.6
	neurological surgery	71.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61531	345	25	EPILEPSY

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61531								

Public Comments

30-Jun-95

AANS	090	20.50
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61531								
AANS	20.50	20.50			1.00	1.00	23.33	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61531								
AANS	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61531									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61531									
AANS				23.33	20.50				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61533 Global Period: 090 Current RVW: 23.41 Recommended RVW: 18.05

CPT Descriptor: **Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended decrease in RVW from 23.41 to 18.05.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	Hvd3 Intra work/min
61533	CRANIOTOMY/INSERTION SUBDURAL ELECTRODES	74	156		180	2004		19.95	23.41	18.05	8.22
61312	CRANIOTOMY/EVAC HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL	75	150		253	2040		20.30	20.54	21.54	7.15
61538	CRANIOTOMY/LOBECTOMY W EECG, TEMPORAL LOBE	90	285		164	2832		31.92	28.05	31.92	7.13

RELATIONSHIP OF 61533 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61533 is presently overvalued in the MFS95 rank order valuation with a RVW of 23.41 which is higher than the RVW of 20.54 for 61312 (CRANIOTOMY/EVAC HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL). Reference to the Harvard3 data on time and total work provides a value of 19.95 for a RVW. This still appears to be high on the scale of values represented by the collection of related procedures ranked by their recommended new values.

Comparison of the Harvard3 time and work values of 61533 to 61312 (CRANIOTOMY/EVAC HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL) shows greater time for the post-service phase of 61312 and a slightly greater total work value. This is reflected in the Harvard3 total work value of 2040 compared to 2004 for 61533. When these work values are translated to RVWs on the 1995 of MFS95, it would place 61533 very close to 61312 (CRANIOTOMY/EVAC HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL) which is clearly a more complex and labor intensive service than 61533. This level of rank order for 61533 is inappropriate, since it is a service done in a non-emergency setting, generally with a limited cranial opening to introduce strips of electrodes over the cerebral surface. The Harvard3 time values are questioned in this context especially the intra-service time of 156 minutes. It seems that over two hours to implant subdural electrodes via craniotomy when one can evacuate an epi- or subdural hematoma in less time represents an anomolous high time estimate.

Also, the Harvard3 intensity of 8.22 represents an unrealistic value for the work per minute of this service, and contributes substantially to the high total work value listed. Since the previous code 61531 had a Harvard3 intensity of 7.00, a reduction in intensity for 61533 is in order and if the same value of 7.00 is used, the total work would drop to approximately 1814 with a corresponding RVW of 18.05, which is the RVW we recommend for 61533.

Code: 61533

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:	Rank order appears appropriate as listed in table after revaluation of intensity for service.
Initial crosswalk or extrapolation misvaluation:	6/91 total work of 1962 increased to 2004 in 3/92 crosswalk extrapolation.
Prev. RUC or Refinement Valuation:	This code was revised editorially in 1992 and reviewed by the RUC with no change in RVW.

Time:

Harvard3 Database:	Time and work values appear higher than realistic compared to other members in family of codes.
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Mental Effort & Judgement:

	The mental effort and judgement of this service are probably comparable to 61312.
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Technical Skill & Physical Effort:

	The skill and effort in this service is less than that for 61312 due to the absence of hematomas in the subdural space with preservation of normal and visible landmarks.
--	---

Stress:

	Stress less than 61312 related to acuity of patient in reference service.
--	---

Intensity/Complexity:

	Harvard3 ratings of intra-service intensity inappropriately high for this service and 61531.
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Public Comments

30-Jun-95

Code: 61533

1995 RVUs: 23.41

Recommended RVUs: 26.64

Ratio:

Long Descriptor: Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring

Reference Set (y/n): N Global Period: 090 Frequency: 64 Impact: 207

Source: 5 Year: 94 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61533	0	0	0	0	100	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61533	99	56	-24.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61533	95	100	2.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61533	group practices	10.7
	neurological surgery	89.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61533	345	25	EPILEPSY

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61533							

30-Jun-95

Public Comments

AANS	090	090	20.35	23.41	1.15	19.76
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61533								
AANS	19.76	23.41	0.97	1.00	1.18	1.00	26.64	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61533								
AANS	090	20.35		38	*	156		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61533									
AANS	*	1.5	*	10	10.5	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61533									
AANS	*	15		26.64	23.41	ns	3		0.083

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61536 Global Period: 090 Current RVW: 29.43 Recommended RVW: 33.49

CPT Descriptor: **Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 29.43 to 33.49.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Harvd3	AANS	Harvd3 to MFS95	MFS95	Rec.New RVW
61534	CRANIECTOMY/EXCISION EPILEPTOGENIC FOCUS W/O EEG	80	199		197	2478		21.77	19.13	
61538	CRANIECTOMY/LOBECTOMY W EEG, TEMPORAL LOBE	90	285		164	2832	2522	31.92	28.05	25.09
61536	CRANIECTOMY/EXCISION EPILEPTOGENIC FOCUS W EEG	88	298		222	3017		33.49	29.43	33.48
61539	CRANIECTOMY/LOBECTOMY W EEG, OTHER LOBE	88	297		221	3045		34.20	30.05	34.20

RELATIONSHIP OF 61536 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

This group of four procedures are different than the previous set of codes, requiring more complex services including resection of cerebral tissue identified as an epileptogenic focus by electrocorticography done during surgery. The reference procedure is 61534 (CRANIECTOMY WITH EXCISION OF EPILEPTOGENIC FOCUS WITHOUT INTRAOPERATIVE ELECTROCORTICOGRAPHY) with a RVW of 19.13. The table compares the work and time values in this group. The Harvard3 work values are reasonable, and when translated to RVWs, provide corrected values that better establish relativity between the associated services. The RVW of 33.49 for 61536 is one of these values and is recommended for such a change.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:
Initial crosswalk or extrapolation misvaluation:
Prev. RUC or Refinement Valuation:

Rank order valuation appropriate as listed in table.

The existing RVWs from the MFS95 are low when compared to the values as calculated from the Harvard3 data, despite the exposure to the RUC in 1992. The RVWs have not been corrected for more accurate valuation to date.

Time:

Harvard3 Database:

Harvard3 data is consistent with rank order and in reference to reference procedure 61534.

Undervalued time/Phase I or II & MFS92:

Mental Effort & Judgement:

Special knowledge and experience are required to properly use information from intra-operative EEG and to integrate that data into decisions about the location and extent of the resection.

Technical Skill & Physical Effort:

The skill and effort involved in a craniectomy with resection of cerebral tissue is clearly higher than a simple lobectomy for tumor.

Stress:

Intensity/Complexity:

The complexity and intensity of these procedures is clearly higher than a simple hematoma evacuation or fracture repair.

Public Comments

Code: 61536

1995 RVUs: 29.43

Recommended RVUs: 33.49

Ratio:

Long Descriptor: Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 27 **Impact:** 110

Source: 4 **Year:** 93 **Public Comment Letter:** 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61536	0	0	0	0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61536	38	26	-16.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61536	100	100	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61536	group practices	15.4
	neurological surgery	84.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61536	191	25	MALIGNANT NEOPLASM OF BRAIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61536							

Public Comments30-Jun-95

AANS	090	090	30.64	29.43	0.96	29.43
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Harvard Data:

Comm	Mawk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61536								
AANS	29.43	29.43	0.96	1.00	1.00	1.00	33.49	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61536								
AANS	090	30.64		48	*	298		65

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61536									
AANS	*	1.5	*	10	13.0	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61536									
AANS	*	15		33.49	29.43	ns	3		0.072

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 61538 Global Period: 090 Current RVW: 28.05 Recommended RVW: 25.09

CPT Descriptor: **Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, temporal lobe**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.
AANS recommended decrease in RVW from 28.05 to 25.09.** Current AAN95 survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old woman with intractable temporal lobe seizures has had extensive EEG monitoring with identification of a seizure focus in the medial temporal lobe. Supplementary SPECT scanning shows metabolic abnormalities in the same suspect area. A craniotomy with resection of the mesial temporal lobe structures is performed.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	Hrvd3 Intra Work/min
61534	CRANIECTOMY/EXCISION EPILEPTOGENIC FOCUS W/O EEG	80	199		197	2478		21.77	19.13		8.48
	CRANIECTOMY/LOBECTOMY W EEG, TEMPORAL LOBE	90	285		164	2832		31.92	28.05		7.48
61536	CRANIECTOMY/LOBECTOMY W EEG, TEMPORAL LOBE	135	210	30	165		2522			25.08 AANS95	7.18
61510	CRANIOTOMY FOR EXCISION BRAIN TUMOR, SUPRATENT. EXCEPT MENINGIOMA	105	200	50	235		2690		23.39	26.77 AANS94	6.98
61536	CRANIECTOMY/EXCISION EPILEPTOGENIC FOCUS W EEG	88	298		222	3017		33.49	29.43	33.49	7.13
61539	CRANIECTOMY/LOBECTOMY W EEG, OTHER LOBE	88	297		221	3045		34.20	30.05	34.20	7.25

RELATIONSHIP OF 61538 TO KEY REFERENCE SERVICES:

This group of four procedures are different than the previous set of codes, requiring more complex services including resection of cerebral tissue identified as an epileptogenic focus by electrocorticography done during surgery. The reference procedure is 61534 (CRANIECTOMY/EXCISION EPILEPTOGENIC FOCUS W/O EEG) with a RVW of 19.13. The table compares the work and time values in this group. The time values for this service in the Harvard3 database show a shorter pre-service time, and additional 75 minutes of intra-service time, no ICU time, and the same post-service time. With intensity factors of 7.48 from Harvard3 and 7.18 from our survey, the final work values reflect these differences with a lower total work for the AANS95 surveyed service, which converts to the 1995 MFS scale as a RVW of 25.09.

Comparison to the basic procedure for excision of a brain tumor, 61510 (CRANIOTOMY FOR EXCISION BRAIN TUMOR, SUPRATENT EXCEPT MENINGIOMA) which has many of the same components of work as 61538, shows that the total work and RVWs are quite similar. The intensity factors, as listed, are also close, which is reasonable in regard to the components of intensity as listed below.

CPT Code: 61538

SURVEY DATA:

Specialty: **Neurological Surgery**

61538	Stats	RVW	LOS (Days)	PRE-SERVICE Time			INTRA TIME (Time)	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
				Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close		ICU/CCU Visits	Other		Dischg Day Mgmt.	Office Visits after discharge			
										O.R.	Recovery Room		Hospital Visits (NOT ICU/CCU)	Time		SUM	No.x	Time	SUM
min	21.00	4	40	10	25	180	20	15	0	0	0	4	5	20	20	1	25	25	
25th%	24.50	5	65	13	28	195	20	15	1	8	8	5	8	38	20	2	28	41	
median	6.53	5	90	15	30	210	20	15	2	15	30	6	10	60	20	2	30	60	
75th%	30.50	5	105	15	38	225	25	18	3	15	45	7	13	88	20	2	30	60	
max	33.00	5	120	15	45	240	30	20	4	15	60	8	15	120	20	2	30	60	
survey n	275																		
RVW resp	3																		
rate %	1%																		

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:
Initial crosswalk or extrapolation misvaluation:

Rank order valuation appropriate as listed in table.
Total work increased in crosswalk from 2784 to 2832.

Time:

AANS95 Survey :
Harvard3 Database:

Time and work data support a decreased RVW.
Intra-service time appears to be high compared to the survey data

Undervalued time/Phase I or II & MFS92:

Time overvalued in Harvard3 data.

Mental Effort & Judgement:

Special knowledge and experience are required to properly use information from intra-operative EECG and to integrate that data into decisions about the location and extent of the resection.

Technical Skill & Physical Effort:

The skill and effort involved in a craniectomy with resection of cerebral tissue is comparable to a simple lobectomy for tumor.

Stress:

Intensity/Complexity:

The complexity and intensity of these procedures is higher than a simple hematoma evacuation or fracture repair.

Public Comments

Code: 61538

1995 RVUs: 28.05

Recommended RVUs: 31.92

Ratio:

Long Descriptor: Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, temporal lobe

Reference Set (y/n): N Global Period: 090 Frequency: 183 Impact: 708

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61538	0	0	0	100	66.7	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61538	203	198	-1.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61538	98.5	100	0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61538	group practices	10.1
	neurological surgery	86.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61538	191	8.3	MALIGNANT NEOPLASM OF BRAIN
	345	8.3	EPILEPSY
	780	8.3	GENERAL SYMPTOMS

Harvard Data:

Public Comments

Comm	Modif	Packlv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61538							
AANS		090	090	28.77	28.05	0.97	28.05

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61538								
AANS	28.05	28.05	0.97	1.00	1.00	1.00	31.92	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61538								
AANS	090	28.77		49		285		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61538									
AANS		1.5	*	10	8.5		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61538									
AANS		15		31.92	28.05	ns	3		0.076

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61542 Global Period: 090 Current RVW: 27.39 Recommended RVW: 29.05

CPT Descriptor: **Craniotomy with elevation of bone flap; for total hemispherectomy**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 27.39 to 29.05.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61543	CRANIECTOMY/PARTIAL HEMISPHERECTOMY	83	231		206	2745		27.32	20.62	27.32
61542	CRANIECTOMY/TOTAL HEMISPHERECTOMY	85	249		212	2919		29.05	27.39	29.05
61546	CRANIOTOMY FOR HYPOPHYSECTOMY	85	255		214	2942		29.28	29.33	

RELATIONSHIP OF 61542 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

Both of these procedures, 61542 & 61543 require an unusual degree of exposure of the brain for the purpose of removal of most of one cerebral hemisphere in treatment of intractable epilepsy. The work of the service lies between the major basal tumor procedures, and the less complex supratentorial tumor procedures. The reference procedure that they adjoin is 61546 (CRANIOTOMY FOR HYPOPHYSECTOMY) which has a total work value of 2942, a time of 255 minutes and a RVW of 29.33. The services are roughly comparable aside from the size of the resection and specific target areas.

The work and time values for 61542 and 61543 are listed in the table for comparison. We recommend for 61542 a RVW of 29.05, which reflects the Harvard3 valuation calculated from the time data.

RATIONALE for recommendation:

Work:	Rank Order (Ordinal) Valuation:	Ordinal valuation appropriate as listed in table.
Time:	Harvard3 Database:	Harvard3 data on time and work only available source at present.
Mental Effort & Judgement:		Mental effort and judgement equivalent to reference procedure 61546.
Technical Skill & Physical Effort:		Amount of skill and effort comparable to that required during craniotomy for pituitary tumor, 61546.
Stress:		
Intensity/Complexity:		Intensity greater than 61510 for brain tumor.

Public Comments

30-Jun-95

Code: 61542

1995 RVUs: 27.39

Recommended RVUs: 29.05

Ratio:

Long Descriptor: Craniotomy with elevation of bone flap; for total hemispherectomy

Reference Set (y/n): N Global Period: 090 Frequency: 1 Impact: 2

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61542	5	.	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61542	100	.	.

Trends Analysis -- Specialty Mix:

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61542							
AANS		090	090	29.65	27.39	0.92	27.39

Harvard Data:

Public Comments

30-Jun-95

Comm	Mawk93	Mfawk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61542								
AANS	27.39	27.39	0.92	1.00	1.00	1.00	29.05	340

Harvard Data:

Comm	Pack95	Hrvtorwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61542								
AANS	090	29.65		46	*	249		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61542									
AANS	*	1.5	*	10	12.5	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfawk95	Sp	Phase	Twput	Iwput
61542									
AANS	*	15		29.05	27.39	ns	3		0.084

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61543 Global Period: 090 Current RVW: 20.62 Recommended RVW: 27.32

CPT Descriptor: **Craniotomy with elevation of bone flap; for partial or subtotal hemispherectomy**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 20.62 to 30.46.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61543	CRANIECTOMY/PARTIAL HEMISPHERECTOMY	83	231		206	2745		27.32	20.62	27.32
61542	CRANIECTOMY/TOTAL HEMISPHERECTOMY	85	249		212	2919		29.05	27.39	29.05
61546	CRANIOTOMY FOR HYPOPHYSECTOMY	85	255		214	2942		29.28	29.33	

RELATIONSHIP OF 61543 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

Both of these procedures, 61542 & 61543 require an unusual degree of exposure of the brain for the purpose of removal of part of most of one cerebral hemisphere in treatment of intractable epilepsy. The work of the service lies between the major basal tumor procedures, and the less complex supratentorial tumor procedures. The reference procedure that they adjoin is 61546 (CRANIOTOMY FOR HYPOPHYSECTOMY) which has a total work value of 2942, a time of 255 minutes and a RVW of 29.33. The services are roughly comparable aside from the size of the resection and specific target areas.

The work and time values for 61542 and 61543 are listed in the table for comparison. We recommend for 61543 a RVW of 27.32, which reflects the Harvard3 valuation calculated from the time data.

RATIONALE for recommendation:

Work:	
Rank Order (Ordinal) Valuation:	Ordinal valuation appropriate as listed in table.
Time:	
Harvard3 Database:	Harvard3 data on time and work only available source at present.
Mental Effort & Judgement:	Mental effort and judgement equivalent to reference procedure 61546.
Technical Skill & Physical Effort:	Skill and effort also compare closely to 61546.
Stress:	
Intensity/Complexity:	Intensity greater than 61510 for brain tumor.

Public Comments

30-Jun-95

Code: 61543

1995 RVUs: 20.62

Recommended RVUs: 30.46

Ratio:

Long Descriptor: Craniotomy with elevation of bone flap; for partial or subtotal hemispherectomy

Reference Set (y/n): N

Global Period: 090

Frequency: 14

Impact: 138

Source: 1

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61543	0	0	0	0	100	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61543	11	18	27.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61543	100	100	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61543	group practices	11.1
	neurological surgery	88.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61543	276	25	DISORDERS OF FLUID, ELECTROLYTE, A
	345	25	EPILEPSY
	486	25	PNEUMONIA, ORGANISM UNSPECIFIED
	997	25	OTHER COMPLICATIONS OF INTERNAL P

Public Comments

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61543							
AANS		090	090	27.88	20.62	0.74	20.62

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61543								
AANS	20.62	20.62	0.74	1.00	1.00	1.00	30.46	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61543								
AANS	090	27.88		44	*	231		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61543									
AANS	*	1.5	*	10	12.0	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61543									
AANS	*	15		30.46	20.62	ns	3		0.084

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61545 Global Period: 090 Current RVW: 34.50 Recommended RVW: 41.76

CPT Descriptor: **Craniotomy with elevation of bone flap; for excision of craniopharyngioma**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 34.50 to 41.76. **Current AANS survey .**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48 year old man has failing vision and headaches. An MRI scan shows enhancement of a 3 by 4 cm suprasellar lesion with cystic compartments that is compressing the anterior third ventricle floor. A craniotomy is done with resection of most of the tumor except for a portion of the wall adherent to the hypothalamus and internal carotid artery.

Description of Pre-Service Work: includes review of previous hospital records from the earlier hemorrhage, evaluation of the imaging studies, review of endocrine data, and appropriate lab studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup.

Description of Intra-Service Work: A scalp flap is outlined and reflected over the fronto-temporal region. The bone flap is turned after placement of one or several burr holes. The lateral sphenoid wing is drilled off. The dura is opened and retracted, exposing the cortex, and the Sylvian fissure is opened to improve access to the suprasellar region. Retractors are placed and the tumor identified beneath and elevating both optic nerves and the chiasm. The margins are dissected away from the regional vessels and brain and cranial nerves. The wall is opened and the center is debulked. All accessible capsule not tightly adherent to adjacent structures is removed. After excision of the lesion and confirmation of hemostasis, the dura is closed, the bone flap replaced and anchored with wires or plates and screws, and the scalp closed in layers. A drain may be placed beneath the scalp. Dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of intracranial bleeding or hypothalamic malfunction. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec.New RVW	Hrwd3 Intra Work/min
61510	CRANIOTOMY FOR EXCISION BRAIN TUMOR, SUPRATENT. EXCEPT MENINGIOMA	165	219		634	2328	2690	23.17	23.39	26.77 AANS94	6.98
61512	CRANIOTOMY FOR EXCISION MENINGIOMA, SUPRATENTORIAL	149	241		596	2411	3368	24.00	24.26	33.51 AANS94	6.91
61546	CRANIOTOMY FOR HYPOPHYSECTOMY	85	255		214	2942		29.28	29.33		8.17
61545	CRANIOTOMY/EXCISION OF CRANIOPHARYNGIOMA	93	337		233	3532		35.15	34.50		7.69
61546	CRANIOTOMY/EXCISION OF CRANIOPHARYNGIOMA	105	300	60	213		4197			41.76 AANS95	10.02
61519	CRANIOTOMY/EXCISION OF MENINGIOMA, INFRATENTORIAL	96	354		198	3417	3978	34.01	33.84	39.58 AANS94	7.31
61526	CRANIOTOMY/EXCISION OF CPA TUMOR, MASTOID APPROACH	96	319		166	3459	5084	34.43	29.71	50.59 AANS94	8.57

Code: 61545

RELATIONSHIP OF 61545 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61545 (CRANIECTOMY FOR EXCISION OF CRANIOPHARYNGIOMA) is a complex and time/intensive procedure designed to remove a tumor in the suprasellar region, frequently attached to the hypothalamus, pituitary stalk and displacing the optic nerves and carotid arteries and their branches. The reference service that most closely approximates the work and techniques of 61545 is 61546 (CRANIOTOMY FOR HYPOPHYSECTOMY) which is somewhat less complex and has lower time and work values (see table). The work values from Harvard3 translate directly into a RVW of 29.33 for the reference procedure, 61546. The Harvard3 work values for 61545 would give a RVW of 35.15 but the current MFS95 has a lower RVW of 34.50. Note that there is no time listed in the Harvard3 data for ICU time, which would occur in all such patients post-operatively, and usually for a number of days. When the intensity factors are considered, it is evident that the Harvard3 work/min of 61546 at 8.17 is greater than the 7.69 for this service 61545, despite the fact that the mental effort, skill, and risks are all higher for 61545 due to the nature of the tumor and the sensitive structures to which it may attach. When we surveyed this service, the intensity factor was substantially increased in relative order to other services of comparable complexity, and the value in the table of 10.02 was used in the calculation of the recommended RVW of 41.76. This is a very high value but the time and intensity factors all support it in that range. Comparison of the total work values for the family of tumor codes listed in the table above also appears appropriate to the rank order valuation in this group of procedures. The recommended RVW for 61512 (CRANIOTOMY FOR EXCISION MENINGIOMA, SUPRATENTORIAL) is 33.51 and has lower total work values than 61545. The RVW recommended for 61545 is therefore increased to better relate to the other procedures in this family of codes and a value of 41.76 is recommended.

SURVEY DATA:

Specialty: Neurological Surgery

61545	Stats	RVW	LOS		PRE-SERVICE Time			INTRA TIME		POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)		
			Days	Hosp Stay	Eval. before	Scrub and	O.R. Entry to	Skin Open to	Skin Close	Skin Close to	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day	Office Visits after discharge			
			Time	Time	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM
min	27.00	5	10	10	10	180	10	0	1	5	5	2	5	10	15	1	10	10
25th%	32.00	7	60	15	25	240	20	15	3	15	45	4	10	40	20	2	15	30
median	38.00	7	60	15	30	300	25	20	4	15	60	5	15	75	30	4	15	53
75th%	40.00	10	90	15	45	350	30	30	6	20	120	7	15	105	30	5	30	150
max	50.00	21	180	30	75	480	60	240	15	40	600	18	30	540	75	10	45	450
survey n	275																	
RVW resp	53																	
rate %	19%																	

RATIONALE for recommendation:

Work: Rank Order (Ordinal) Valuation: Rank order of 61545 within family is appropriate per recommended RVW of 36.70.

Prev. RUC or Refinement Valuation: No change in RVW in 5/92 refinement panel.

Time: Op. Logs: 2 cases with avg. time of 310 min.
 AANS95 Survey: See table above.
 Harvard3 Database: Harvard3 data supports an increase in RVW above the current 34.50.
 Undervalued time/Phase I or II & MFS92: It appears that an unexplained reduction in RVW was imposed relative to the Harvard3 database.

Mental Effort & Judgement: High degree of knowledge and judgment during planning and performance of procedure due to the important adjacent structures.

Technical Skill & Physical Effort: High skill required to remove tumor without damage to optic nerves, regional vessels or hypothalamus.

Stress: Mod. high stress carried over into ICU with frequent diabetes insipidus and pituitary insufficiency.

Intensity/Complexity: Very complex with high intensity factor compared to 61546.

Public Comments

30-Jun-95

Code: 61545 1995 RVUs: 34.5 Recommended RVUs: 36.70 Ratio:

Long Descriptor: Craniotomy with elevation of bone flap; for excision of craniopharyngoma

Reference Set (y/n): N Global Period: 090 Frequency: 32 Impact: 70

Source: 4 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

[Empty comment box]

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61545	0	0	0	0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61545	25	34	16.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61545	96	100	2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61545	group practices	5.9
	neurological surgery	94.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61545	191	25	MALIGNANT NEOPLASM OF BRAIN

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61545								

30-Jun-95

Public Comments

AANS	090	090	35.87	34.50	0.96	34.50
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61545								
AANS	34.50	34.50	0.96	1.00	1.00	1.00	36.70	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61545								
AANS	090	35.87		51	*	337		65

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	lcuvis	Offvis
61545									
AANS	*	1.5	*	10	13.5	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61545									
AANS	*	15		36.70	34.50	ns	3		0.078

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61576 Global Period: 090 Current RVW: 33.82 Recommended RVW: 50.08

CPT Descriptor: **Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion; requiring splitting of tongue and/or mandible (including tracheostomy)**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.
AANS recommended increase in RVW from 33.82 to 50.08.** Current AANS95 survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59 year old man has ataxia, diplopia and headaches. An MRI scan shows enhancement of a 3 by 5 cm lesion involving the clivus from the pontomedullary junction down to C2. The medulla and pons are displaced posteriorly, with narrowing of the fourth ventricle. A transoral approach to the clivus and C1-2 is done with splitting the tongue and mandible. A prophylactic tracheostomy is also done. After resection of the lower clivus a meningioma is seen attached loosely to the dura. Most of the tumor except for a portion of the wall densely adherent to the dura is resected. After confirmation of hemostasis, the posterior pharyngeal wall is carefully closed, and the tongue and mandible reapproximated.

Description of Pre-Service Work: includes review of hospital records, evaluation of the imaging studies, and appropriate lab studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup.

Description of Intra-Service Work: The mouth and pharynx are exposed with appropriate retractors. A tracheotomy is installed. The tongue and mandible are divided in the midline and retractors are adjusted. The posterior pharyngeal wall is incised in the midline and lifted off the underlying clivus and anterior vertebral surfaces down to C2. Bone is drilled away to expose the tumor. The tumor is debulked and the wall identified. The margins are dissected away from dura to the extent possible. All accessible capsule not tightly adherent to adjacent structures is removed. After excision of the lesion and confirmation of hemostasis, the posterior pharyngeal wall is closed in layers. The tongue and mandible are reapproximated with sutures and wire. Packing is applied to the posterior pharyngeal wall

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of complications and hemorrhage. The hospital visits and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	Hrvd3 Intra Work/min
61597	TRANSCONDYLAR APPROACH TO POST. FOSSA, JUG FORAMEN OR MIDLINE SKULL BASE, INCLUDE OCCIP CONDYLECTOMY MASTOIDECTOMY	191	368		403				36.12		
61519	CRANIECTOMY/EXCISION OF MENINGIOMA, INFRATENTORIAL	96	354		198	3417	3978	34.01	33.84	39.58	9.54
61616	RESECTION OF NEOPLASTIC, VASC OR INFECT LESION BASE OF POST FOSSA, JUG FORAMEN OR C1-3 VERT BODIES EXTRADURAL	136	215		400				41.29		
61545	CRANIECTOMY/EXCISION OF CRANIOPHARYNGIOMA	93	337		233	3532	4197	35.15	34.50	41.76	10.02
61521	CRANIECTOMY/EXCISION OF MIDLINE TUMOR @ BASE OF SKULL	98	411		247	3958		39.39	39.48	42.20	7.19
61530	CRANIECTOMY/EXCISION CPA TUMOR/MID-POST FOSSA APPROACH	87	492		182	4134		41.15	42.35		6.87
61576	TRANSORAL APPROACH TO SKULL BASE REQ TONGUE SPLITTING & OR MANDIBL	91	277		226	3858		38.40	33.82	42.40	10.63
61576	TRANSORAL APPROACH TO SKULL BASE REQ TONGUE SPLITTING & OR MANDIBLE	128	363	75	223		5033			50.08 AANS95	10.14

Code: 61576

RELATIONSHIP OF 61576 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61576 (TRANSORAL APPROACH TO SKULL BASE REQ. TONGUE SPLITTING &/OR SPLIT MANDIBLE) is a very complex and rarely performed procedure designed to provide access to lesions at the junction between the atlas, axis and the clivus. In terms of work, it compares most closely to the reference procedures 61521 and 61530, both of which describe procedures that deal with tumors in the same general territory of the head. The RVW of 61530 is appropriate in a rank order valuation to the adjoining procedures, and by comparison supports a recommendation that the value of 61576 above 42.40.

The Harvard3 data for 61576 supports a RVW of 38.40, but this is inaccurate due to the failure to include substantial ICU time and work in the total work product, as in the example from the AANS95 survey which includes 75 minutes of ICU time. Also the pre-service and intra-service times from the survey are both substantially higher than from the Harvard3 database. When the survey intensity of 10.14 (which compares closely to the Harvard3 intensity of 10.63) is used to calculate a total work value, the result is 5033, which converts to the MFS95 at a RVW of 50.08.

In another comparison, the combination of 61597 and 61616 as skull base procedures can be used in place of 61521 to approach and resect a midline lesion at the anterior skull base. Using both of these codes, a summation of their RVWs, even with a multiple procedure 50 % reduction for the second procedure, amounts to about 56 RVWs.

SURVEY DATA:

Specialty: **Neurological Surgery**

Stats	RVW	LOS	PRE-SERVICE TIME		INTRA TIME		POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
			Days	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time		
min	25.00	5	15	10	10	240	10	0	2	5	10	3	5	15	15	1	10	10
25th%	32.67	8	60	15	30	300	25	20	4	15	60	5	15	75	20	2	15	30
median	36.00	10	68	15	45	360	30	20	5	15	75	6	15	90	30	4	15	53
75th%	42.00	12	120	15	60	480	39	30	6	20	120	8	15	120	30	5	20	95
max	50.00	21	180	30	150	600	90	180	20	30	600	14	20	280	60	6	30	180
survey n	275																	
RVW resp	31																	
rate %	11%																	

RATIONALE for recommendation:

Work: Rank Order (Ordinal) Valuation: Rank order valuation of total work and Rec. RVWs in the table is appropriately ranked.

Initial crosswalk or extrapolation misvaluation: Initial valuation only 3858 total work.

Time: Harvard3 Database: Undervalued total work due to missing ICU time and underestimation of pre- and intra-service times.

Undervalued time/Phase I or II & MFS92: Present MFS95 RVW of 33.82 is undervalued relative to the Harvard3 data and when compared to other procedures in family.

Mental Effort & Judgement: Complex strategy involved in approach and resection of lesions in region of clivus or craniovertebral junction.

Technical Skill & Physical Effort: High level of skill, effort and experience. A tracheotomy is usually required to assure a good airway.

Stress: High risk and stress due to the location of the lesions and danger of infection/meningitis following closure.

Intensity/Complexity: Procedure is very complex considering the unusual approach to the target area through the mouth, possibly with splitting of the tongue and mandible.

Public Comments

30-Jun-95

Code: 61576

1995 RVUs: 33.82

Recommended RVUs: 42.40

Ratio:

Long Descriptor: Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion: requiring splitting of tongue and/or mandible (including tracheostomy)

Reference Set (y/n): N Global Period: 090 Frequency: 11 Impact: 94

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment: AAFP

Trends Analysis - Beneficiary Information:

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
61576	14	14	0

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61576	85.7	71.4	-7.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
61576	general surgery	14.3
	neurological surgery	14.3
	otolaryngology	71.4

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61576							

30-Jun-95

Public Comments

AANS	090	090	39.18	33.82	0.86	33.82
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61576								
AANS	33.82	33.82	0.86	1.00	1.00	1.00	42.40	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61576								
AANS	090	39.18		50	*	277		65

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
61576									
AANS	*	1.5	*	10	13.5	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61576									
AANS	*	15		42.40	33.82	ns	3		0.108

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61680 Global Period: 090 Current RVW: 36.45 Recommended RVW: 29.13

CPT Descriptor: **Surgery of intracranial arteriovenous malformation; supratentorial, simple**

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended a decrease in RVW from 36.45 to 29.13. Current AANS95 survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50 year old man has seizures related to a small cortical arteriovenous malformation (AVM) of the parietal lobe and a history of a previous hemorrhage. The lesion does not involve the deep venous draining structures. A craniotomy provides exposure of the lesion which is totally excised.

Description of Pre-Service Work: includes review of previous hospital records from the earlier hemorrhage, evaluation of the angiogram and imaging studies, review of EEG information, and appropriate lab studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup.

Description of Intra-Service Work: A scalp flap is outlined and reflected centered over the lesion. The bone flap is turned after placement of one or several burr holes. The dura is opened and retracted, exposing the cortex and the lesion. The margins are dissected away from the cortex and white matter with serial clipping and division of the feeding and then the draining vessels. Any included aneurysmal formations on feeding vessels are clipped and isolated. After complete excision of the lesion and confirmation of hemostasis, the dura is closed, the bone flap replaced and anchored with wires or plates and screws, and the scalp closed in layers. A drain may be placed beneath the scalp. Dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of intracranial bleeding or seizures. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec. New RVW	Intra Work /mln Hrvd3 AANS95
61680	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENTORIAL, SIMPLE	82	265		184	3562		35.45	36.45		10.60 Hrvd3
61680	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENTORIAL, SIMPLE	105	240	38	165		2927			29.13 AANS96	8.61 AANS95
61684	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, INFRATENT. SIMPLE	92	288		206	4015		39.96	39.25	39.96	11.01 9.20
61692	SURGERY OF AV MALFORMATION, DURAL COMPLEX	97	363		243	4212		41.92	37.96	41.92	8.90 10.51
61702	SURGERY OF INTRACRANIAL ANEURYSM, VERTEBRAL-BASILAR CIRC	78	345		234	4471		44.50	39.20	44.50	10.51 10.98
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	103	280		256	3470		34.54	34.83		8.68
61780	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	120	270	98	313		4854			48.30 AANS94	12.72 AANS95
61682	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENT. COMPLEX	96	446		225	5156		51.32	42.21	51.32	9.50 11.09
61686	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, INFRATENT. COMPLEX	104	505		232	5678		56.51	47.45	56.51	9.35 12.12

Code: 61680

RELATIONSHIP OF 61680 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The proposed new RVWs for this group of procedures are based on rank order valuation supplemented by current survey data for the key reference 61700 and several of the other vascular codes. The justification for the increases is based on the AANS94 and 95 surveys (see Table 1 in Appendix and Survey95 results below). Significant differences between the Harvard3 time data and our Survey95 data are present. There is less intra- and post-service time in our survey data but there is 38 minutes of ICU time, which is higher intensity service than regular post-operative visits. In addition, the survey specifically requested an estimation of each of the three components of intensity, along with a rating of the complexity of each phase of the service, pre-, intra- and post-. The survey respondents provided realistic appraisals of the components of intensity for each surveyed service, and the present intensity value listed is a calculated and adjusted average of this same survey data.

When this new time and intensity data are entered into the calculation of work, the AANS95 survey produces a total work value of 2927 compared to the Harvard3 total work of 3562.. When this is converted into RVWs (1995), the total work RVWs are 29.13 which is the recommended value.

The other procedures, 61680 to 61686, are rank ordered above the benchmark 61700, and use of Harvard3 total work comparisons further supports the scaling as indicated. All but 61680 have recommended RVWs based on the Harvard3 database as converted to the 1995 MFS values, and all have comparable Pre- and Post-service time increases over the Harvard3 benchmark valuation. The time data for Pre- and Post-service times for these four codes listed in the Harvard3 database will all be undervalued based on the time compression analysis described in the introduction. The amount of the time compression will not be clear until these codes are surveyed. Consequently, use of the Harvard3 RVWs as translated to the MFS95 are proposed as partially corrected RVWs. The RVW for 61680 places the value as the lowest in this family, below 61700 and the next higher procedure, 61684, since it logically falls into that position on a scale of comparative work, mental effort, technical skill, stress and intensity.

Note that 61680 was assigned a total work value of 3899 in the June 1991 cross specialty scale but was reduced to 3562 in the May 1992 review of the linkages. In May 1992, the Refinement Panel working from a 1992 RVW of 0 recommended a RVW of 1.0 which has resisted subsequent challenges to date.

SURVEY DATA:

Specialty: Neurological Surgery

CPT 61680	Stats	RVW	LOS	PRE-SERVICE Time			INTR A TIME	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global)		
				Time	Time	Time		Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM
	min	21.00	4	15	10	10	100	10	0	0	0	0	1	10	10	15	1	5	5
	25th%	25.00	5	45	15	25	200	20	16	2	15	30	3	10	30	20	2	15	30
	median	34.00	6	60	15	36	240	20	20	3	15	38	4	15	60	28	3	15	45
	75th%	35.00	7	60	15	45	300	30	30	4	20	80	5	15	75	30	4	30	120
	max	45.00	10	120	30	120	3000	60	120	8	40	320	9	30	270	60	8	30	240

surveyn	275
RVW resp	51
rate %	19%

CPT Code: 61680

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation: The rank order for this series of codes was carefully developed and verified. It provides the basis for revaluation of 61860.

Initial crosswalk or extrapolation misvaluation: This code was reduced from 3899 total work to 3562 in 1991-1992 crosswalk extrapolation.

Prev. RUC or Refinement Valuation: These codes were considered at the May92 Refinement Panel but the proposed increases were not accepted.

Time:

3 cases; avg. time = 242 min.

Op. Logs: 4 cases; avg. anesth. time = 315 min.

Anesthesia databases: 3 cases; avg. anesth. time=321 min.

Mental Effort & Judgement: High, especially when sustained for several hours.

Technical Skill & Physical Effort: Comparable to a difficult brain tumor procedure.

Stress: Relatively high compared to non-vascular procedures, but relatively low compared to other services in this family.

Intensity/Complexity: Moderately high.

Public Comments

30-Jun-95

Code: 61680	1995 RVUs: 36.45	Recommended RVUs: 38.20	Ratio:
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Long Descriptor: Surgery of intracranial arteriovenous malformation; supratentorial, simple**Reference Set (y/n):** N **Global Period:** 090 **Frequency:** 73 **Impact:** 128**Source:** 7 **Year:** 94 **Public Comment Letter:** 340**Reference Services:****CMD Comment:**

Societies Wishing to Survey: AANS**Societies Wishing to Comment:****Trends Analysis -- Beneficiary Information:**

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61680	166	88	-27.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61680	100	93.2	-3.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61680	group practices	6.8
	neurological surgery	93.2

Claims-Level Diagnosis Information:**Harvard Data:**

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61680							
	AANS	090	090	36.18	36.45	1.01	0.00

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61680								
AANS	36.45	36.45	0.00		1.00	1.00	38.20	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61680								
AANS	090	36.18						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61680									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61680									
AANS				38.20	36.45	ns	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61682 Global Period: 090 Current RVW: 42.21 Recommended RVW: 59.47

CPT Descriptor: **Surgery of intracranial arteriovenous malformation; supratentorial, complex**

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended an increase in RVW fro 42.21 to 59.47. Current AANS95 survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38 year old woman has seizures and during her workup is found to have a large arteriovenous malformation (AVM) deep in the temporal lobe with multiple large arterial feeders and draining into the deep venous structures. A craniotomy is done to expose the lesion and the lesion is isolated from the circulation and excised.

Description of Pre-Service Work: includes review of the angiogram and imaging studies, review of EEG information, and appropriate lab studies. Pre-service work includes extensive informed consent with the patient and family, plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup.

Description of Intra-Service Work: A scalp flap is outlined and reflected over the lesion. The bone flap is turned after placement of one or several burr holes. The dura is opened and retracted, exposing the brain. The AVM is exposed by opening the cortex and white matter over the lesion. The margins are dissected away from the cortex and white matter with serial clipping and division or embolization of the feeding vessels. The draining vessels are isolated and sealed, then divided. Any included aneurysmal formations on feeding vessels are clipped and isolated. After complete excision of the lesion and confirmation of hemostasis, the dura is closed, the bone flap replaced and anchored with wires or plates and screws, and the scalp closed in layers. A drain may be placed beneath the scalp. Dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of intracranial bleeding or seizures. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec. New RVW	Intra Work /mla Hrwd3 AANS95
61680	SURG/INTRACRAN ARTERIO-VEINUS MALFORMATION, SUPRATENTORIAL, SIMPLE	82	265		184	3562		35.45	36.45		10.60 Hrwd3
61680	SURG/INTRACRAN ARTERIO-VEINUS MALFORMATION SUPRATENTORIAL, SIMPLE	105	240	38	165		2927			29.13 AANS95	8.61 AANS95
61684	SURG/INTRACRAN ARTERIO-VEINUS MALFORMATION, INFRATENT, SIMPLE	92	288		206	4015		39.96	39.25	39.96	11.01 9.20
61692	SURGERY OF AV MALFORMATION, DURAL, COMPLEX	97	363		243	4212		41.92	37.96	41.92	8.90 10.51
61702	SURGERY OF INTRACRANIAL ANEURYSM, VERTEBRAL-BASILAR CIRC	78	345		234	4471		44.50	39.20	44.50	10.51 10.98
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	103	280		256	3470		34.54	34.83		8.68
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	120	270	98	313		4854			48.30 AANS94	12.72 AANS95
61682	SURG/INTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENT, COMPLEX	96	446		225	5156		51.32	42.21	51.32	9.50 11.09
61682	SURG/INTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENT, COMPLEX	120	420	60	230		5976		42.21	59.47 AANS95	11.09
61686	SURG/INTRACRAN ARTERIO-VEINUS MALFORMATION, INFRATENT, COMPLEX	104	505		232	5678		56.51	47.45	56.51	9.35 12.12

CPT Code: 61682

RELATIONSHIP OF 61682 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The proposed new RVWs for this group of procedures are based on rank order valuation supplemented by current survey data for the key reference 61700 and several of the other vascular codes. The justification for the increases is based on the AANS94 and 95 surveys (see Table 1 in Appendix and Survey95 results below). Significant differences between the Harvard3 time data and our Survey95 data are present. There is less intra- but more pre- and post-service time in our survey data as well as 60 minutes of ICU time, which is higher intensity service than regular post-operative visits. In addition, the survey specifically obtained an estimate of each of the three components of intensity, along with a rating of the complexity of each phase of the service, pre-, intra- and post-. The survey respondents provided realistic appraisals of the components of intensity for each surveyed service, and the present intensity value listed is a calculated and adjusted average of this same survey data. Application of this data to calculation of a new RVW for this service results in our recommended RVW of 59.47.

The other procedures, 61680 to 61686, are rank ordered around the benchmark 61700. All have recommended RVWs based on the AANS95 survey data as converted to the 1995 MFS values, and all have comparable Pre- and Post-service time increases over the Harvard3 benchmark valuation. The time data for Pre- and Post-service times for these four codes listed in the Harvard3 database will all be undervalued based on the time compression analysis described in the introduction. The amount of the time compression is most easily seen in the amount of ICU time from our survey. When this work is added back to the work of the other portions of the service, the total work values reflect this increase and help to relieve the compression that occurred in the Harvard3 database. The RVW for 61682 is a calculated value derived from the AANS95 time and work data that places this procedure between 61700 and the next higher procedure, 61686, since it logically falls into that position on a scale of comparative work, mental effort, technical skill, and risk-stress.

Note that 61682 was assigned a total work value of 5668 in the June 1991 cross specialty extrapolation but was reduced to 5156 in the March 1992 review of the linkages. In May 1992, the Refinement Panel working from a 1992 RVW of 0 recommended a RVW of 43.24 which has resisted subsequent challenges to date. If the original June 1991 work value had been maintained, the current RVW would be approximately 50.52.

SURVEY DATA:

Specialty: Neurological Surgery

61682	Stats	RVW	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global)	
			Days	Eval.	Scrub	O.R. Entry to	Skin Open to	Skin Close to	ICU/CCU Visits	Other			Disch g Day Mgmt.	Office Visits after discharge				
				Hosp. Stay	before O.R.	and Dress	to Skin Open	to Skin Close		to Recovery Room	No.x	Time			SUM	No.x	Time	SUM
min	30.00	5	7	10	15	200	10	0	2	5	10	3	10	30	15	1	15	15
25th%	38.00	7	45	15	30	360	20	20	3	15	45	5	15	75	20	2	15	30
median	40.00	8	70	15	35	420	30	20	4	15	80	6	15	90	35	3	20	60
75th%	45.00	10	120	20	60	480	40	45	6	20	120	7	15	105	30	4	30	120
max	70.00	69	180	30	180	825	105	120	64	60	3840	26	30	780	45	8	45	360
survey n	275																	
RVW resp	43																	
rate %	16%																	

CPT Code: 61682

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation: The rank order for this series of codes was carefully developed and verified. It provides the basis for revaluation of 61860.

Initial crosswalk or extrapolation misvaluation: This code was reduced from 5668 total work to 5156 in 1991-1992 crosswalk extrapolation.

Prev. RUC or Refinement Valuation: These codes were considered at the May92 Refinement Panel but the proposed increases were not accepted.

Time:

Op. Logs: 5 cases; avg. time = 484 min.

Anesthesia databases: 3 cases; avg. anesth. time=321 min.

Harvard3 Database: Data in the table suggests undervaluation in the Harvard3 database.

Mental Effort & Judgement: Very high, especially when sustained for several hours.

Technical Skill & Physical Effort: Among the highest in the specialty.

Stress: Very high considering the narrow margin between success and disaster during dissection of these delicate vessels.

Intensity/Complexity: Very high.

Public Comments

30-Jun-95

Code: 61682 1995 RVUs: 42.21 Recommended RVUs: 51.32 Ratio:

Long Descriptor: Surgery of intracranial arteriovenous malformation; supratentorial, complex

Reference Set (y/n): N Global Period: 090 Frequency: 133 Impact: 1212

Source: 7 Year: 94 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61682	22.2	0	12.5	77.8	33.3	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61682	117	160	17.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61682	97.4	100	1.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61682	group practices	16.3
	neurological surgery	80
	neurology	2.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61682	191	2.8	MALIGNANT NEOPLASM OF BRAIN
	331	2.8	OTHER CEREBRAL DEGENERATIONS
	430	5.6	SUBARACHNOID HEMORRHAGE
	431	2.8	INTRACEREBRAL HEMORRHAGE

Public Comments

30-Jun-95

434	2.8	OCCLUSION OF CEREBRAL ARTERIES
437	2.8	OTHER AND ILL-DEFINED CEREBROVAS
447	2.8	OTHER DISORDERS OF ARTERIES AND A
747	13.9	OTHER CONGENITAL ANOMALIES OF CI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61682							
AANS		090	090	52.36	42.21	0.81	0.00

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61682								
AANS	42.21	42.21	0.00		1.00	1.00	51.32	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61682								
AANS	090	52.36						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
61682									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61682									
AANS				51.32	42.21	ns	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61684 Global Period: 090 Current RVW: 39.25 Recommended RVW: 38.23

CPT Descriptor: **Surgery of intracranial arteriovenous malformation; infratentorial, simple**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.
AANS recommended a decrease in RVW from 39.25 to 38.23.** Current AANS95 survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old man has a history of a previous subarachnoid hemorrhage due to an arteriovenous malformation (AVM) of the cerebellar hemisphere. The lesion does not involve the deep venous structures. A suboccipital craniectomy provides exposure of the cerebellum and the lesion is totally excised.

Description of Pre-Service Work: includes review of previous hospital records from the earlier hemorrhage, evaluation of the angiogram and imaging studies, and appropriate lab and screening studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup. Positioning is lengthy due to the use of a prone position and stabilization of the patient's head in a pin fixation device.

Description of Intra-Service Work: A scalp flap is outlined and reflected over the lesion. The bone flap is turned after placement of one or several burr holes. The dura is opened and retracted, exposing the cortex and the lesion. The margins are dissected away from the cortex and white matter with serial clipping and division of the feeding and then the draining vessels. Any included aneurysmal formations on feeding vessels are clipped and isolated. After complete excision of the lesion and confirmation of hemostasis, the dura is closed, the bone flap replaced and anchored with wires or plates and screws, and the scalp closed in layers. A drain may be placed beneath the scalp. Dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of intracranial bleeding or seizures. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec. New RVW	Intra Work/min Hrwd3 AANS95
61680	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENTORIAL, SIMPLE	82	265		184	3562		35.45	36.45		10.60 Hrwd3
61680	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENTORIAL, SIMPLE	105	240	38	165		2927			29.13 AANS95	8.61 AANS95
61684	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, INFRATENT. SIMPLE	92	288		206	4015		39.96	39.25	39.96	11.01
61684	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, INFRATENT. SIMPLE	120	300	45	180		3842		39.25	38.23	9.20 AANS95
61692	SURGERY OF AV MALFORMATION, DURAL, COMPLEX	97	363		243	4212		41.92	37.96	41.92	8.90 10.51
61702	SURGERY OF INTRACRANIAL ANEURYSM, VERTEBRAL-BASILAR CIRC.	78	345		234	4471		44.50	39.20	44.50	10.51 10.98
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC.	103	280		256	3470		34.54	34.83		8.68
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC.	120	270	98	313		4854			48.38 AANS94	12.72 AANS95
61682	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENT. COMPLEX	120	420	60	230		5976		42.21	59.47 AANS95	11.08
61686	SURGINTRACRAN. ARTERIO-VEINUS MALFORMATION, INFRATENT. COMPLEX	104	505		232	5678		56.51	47.45	56.51	9.35 12.12

Code: 61684

RELATIONSHIP OF 61684 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The proposed new RVWs for this group of procedures are based on rank order valuation supplemented by current survey data for the key reference 61700 and several of the other vascular codes. The justification for the increases is based on the AANS94 and 95 surveys (see Table 1 in Appendix and Survey95 results below). Significant differences between the Harvard3 time data and our Survey95 data are present. There is less intra- and post-service time but more pre-service time in our survey data as well as 45 minutes of ICU time. In addition, the survey specifically obtained an estimate of each of the three components of intensity, along with a rating of the complexity of each phase of the service, pre-, intra- and post-. The survey respondents provided appraisals of the components of intensity for each surveyed service, and the present intensity value listed is a calculated and adjusted average of this same survey data. The survey intensity factor is 9.20 compared to the Harvard3 factor of 11.01. When these intensity differences are applied to the calculation of total work, the Harvard3 value is 4015 while the result from the AANS95 survey is 3842. This translates to a RVW of 38.23 which is our recommended value.

The other procedures, 61680 to 61686, are rank ordered around the benchmark 61700, and use of Harvard3 and AANS survey total work comparisons further supports the scaling as indicated..

The RVW for 61684 is calculated from the AANS95 survey time and work data and places the value between 61680 and the next higher procedure 61692, since it logically falls into that position on a scale of comparative work, mental effort, technical skill, stress and intensity.

Note that 61684 was assigned a total work value of 4435 in the June 1991 cross specialty scale but was reduced to 4015 in the March 1992 review of the linkages. In May 1992, the Refinement Panel working from a 1992 RVW of 0 recommended a RVW of 40.21 which has resisted subsequent challenges to date. If the original June 1991 work value had been maintained, the current RVW would be approximately 43.46.

SURVEY DATA:

Specialty: Neurological Surgery

61684	Stats	RVW	LOS	PRE-SERVICE Time			INTR A TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
			Hosp. Stay	Eval. before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Disch g Day Mgmt	Office Visits after discharge						
			Days	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM	
	min	25.00	4	15	10	15	30	10	0	0	0	0	2	5	10	15	1	10	10
	25th%	32.25	6	45	15	30	240	20	20	3	15	45	4	10	40	20	2	15	30
	median	38.00	7	60	15	45	300	30	20	3	15	45	4	15	60	25	3	15	45
	75th%	39.72	7	90	20	60	300	40	35	4	20	80	5	15	75	30	4	30	120
	max	45.00	42	150	30	130	720	60	120	35	60	2100	7	30	210	75	8	30	240
survey n	275																		
RVW resp	46																		
rate %	17%																		

CPT Code: 61684

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

The rank order for this series of codes was carefully developed and verified. It provides the basis for revaluation of 61860.

Initial crosswalk or extrapolation misvaluation:

This code was reduced from 4435 total work to 4015 in 1991-1992 crosswalk extrapolation.

Prev. RUC or Refinement Valuation:

These codes were considered at the May92 Refinement Panel but the proposed increases were not accepted.

Time:

Anesthesia databases:

3 cases; avg. anesth. time=321 min.

Harvard3 Database:

Data in the table suggests undervaluation in the Harvard3 database.

Mental Effort & Judgement:

Very high, especially when sustained for several hours.

Technical Skill & Physical Effort:

In the highest group of codes in the specialty.

Stress:

High considering the narrow margin between success and disaster during dissection of these delicate vessels.

Intensity/Complexity:

Moderately high.

Public Comments

30-Jun-95

Code: 61684 1995 RVUs: 39.25 Recommended RVUs: 39.96 Ratio:

Long Descriptor: Surgery of intracranial arteriovenous malformation; infratentorial, simple

Reference Set (y/n): N Global Period: 090 Frequency: 5 Impact: 4

Source: 7 Year: 94 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: A-ANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61684	0	0	0	0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61684	19	8	-35.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61684	89.5	100	5.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61684	anesthesiology	25
	neurological surgery	75

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61684	331	25	OTHER CEREBRAL DEGENERATIONS
	747	25	OTHER CONGENITAL ANOMALIES OF CI

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61684							
AANS		090	090	40.78	39.25	0.96	0.00

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61684								
AANS	39.25	39.25	0.00		1.00	1.00	39.96	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61684								
AANS	090	40.78						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61684									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61684									
AANS				39.96	39.25	ns	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 61686 Global Period: 090 Current RVW: 47.45 Recommended RVW: 62.08

CPT Descriptor: **Surgery of intracranial arteriovenous malformation; infratentorial, complex**

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended increase in RVW from 47.45 to 62.08. Current AANS95 survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 28 year old woman has a history of a previous subarachnoid hemorrhage due to an arteriovenous malformation (AVM) of the cerebellar hemisphere that extends into the cerebellar peduncle. The lesion drains into the deep venous structures and there is one aneurysm seen on a feeding vessel within the AVM. A suboccipital craniectomy provides exposure of the cerebellum and the lesion is totally excised.

Description of Pre-Service Work: includes review of previous hospital records from the earlier hemorrhage, evaluation of the angiogram and imaging studies, and appropriate lab and screening studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup. Positioning is lengthy due to the use of a prone position and stabilization of the patient's head in a pin fixation device.

Description of Intra-Service Work: A suboccipital incision is made to separate the posterior cervical and suboccipital muscles. The suboccipital bone is exposed, retractors applied and a craniectomy is done after placement of one or several burr holes. The dura is opened and retracted, exposing the cerebellar cortex. The cerebellum is incised to expose the surface of the AVM. The margins are dissected away from the white matter with serial clipping and division of the feeding and then the draining vessels, including those components involving the peduncle. The aneurysm on the feeding vessel is clipped and isolated while sparing the major vessels feeding the brainstem. After complete excision of the lesion and confirmation of hemostasis, the dura is closed. The suboccipital and posterior cervical muscles and fascia and the scalp are closed in layers. A drain may be placed in the extradural space. Dressings are applied after the patient is removed from the fixation device and turned supine.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of intracranial bleeding or seizures. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec. New RVW	Intra Work /min Hrwd3 AANS95
61680	SURG/INTRACRAN. ARTERIO-VENOUS MALFORMATION, SUPRATENTORIAL, SIMPLE	82	265		184	3562		35.45	36.45		10.60 Hrwd3
61680	SURG/INTRACRAN. ARTERIO-VENOUS MALFORMATION, SUPRATENTORIAL, SIMPLE	105	240	38	185		2927			29.13 AANS95	8.61 AANS95
61684	SURG/INTRACRAN. ARTERIO-VENOUS MALFORMATION, INFRATENT. SIMPLE	92	288		206	4015		39.96	39.25	39.96	11.01 9.20
61692	SURGERY OF AV MALFORMATION, DURAL, COMPLEX	97	363		243	4212		41.92	37.96	41.92	8.90 10.51
61702	SURGERY OF INTRACRANIAL ANEURYSM, VERTEBRAL-BASILAR CIRC	78	345		234	4471		44.50	39.20	44.50	10.51 10.98
61780	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	103	280		256	3470		34.54	34.83		8.68
61780	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	120	270	98	313		4854			48.30 AANS94	12.72 AANS95
61682	SURG/INTRACRAN. ARTERIO-VENOUS MALFORMATION, SUPRATENT. COMPLEX	120	420	60	230		5976		42.21	59.47 AANS96	11.09 AANS95
61686	SURG/INTRACRAN. ARTERIO-VENOUS MALFORMATION, INFRATENT. COMPLEX	104	505		232	5678		56.51	47.45		9.35 12.12
61686	SURG/INTRACRAN. ARTERIO-VENOUS MALFORMATION, INFRATENT. COMPLEX	135	420	75	250		6238			62.08 AANS95	12.12 AANS95

RELATIONSHIP OF 61686 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The proposed new RVWs for this group of procedures are based on rank order valuation supplemented by current survey data for the key reference 61700 and several of the other vascular codes. The justification for the increases is based on the AANS94 and 95 surveys (see Table 1 in Appendix and Survey95 results below). Significant differences between the Harvard3 time data and our Survey95 data are present. There is less intra- but more pre- and post-service time in our survey data as well as 75 minutes of ICU time, which is higher intensity service than regular post-operative visits. In addition, the survey specifically obtained an estimate of each of the three components of intensity, along with a rating of the complexity of each phase of the service, pre-, intra- and post-. The survey respondents provided realistic appraisals of the components of intensity for each surveyed service, and the present intensity value listed is a calculated and adjusted average of this same survey data. Application of this data to calculation of a new RVW for this service results in our recommended RVW of 62.08.

The other procedures, 61680 to 61686, are rank ordered around the benchmark 61700. All have recommended RVWs based on the AANS95 survey data as converted to the 1995 MFS values, and all have comparable Pre- and Post-service time increases over the Harvard3 benchmark valuation. The time data for Pre- and Post-service times for these four codes listed in the Harvard3 database will all be undervalued based on the time compression analysis described in the introduction. The amount of the time compression is most easily seen in the amount of ICU time from our survey. When this work is added back to the work of the other portions of the service, the total work values reflect this increase and help to relieve the compression that occurred in the Harvard3 database.

The RVW for 61686 is derived from the AANS95 survey data and places the value above 61682 as the highest procedure in this family, since it logically falls into that position on a scale of comparative work, mental effort, technical skill, stress and intensity. The intensity factors that have been described for the earlier codes are 9.35 from Harvard3 and 12.12 from the AANS survey. This high value fits into the scale of the highest intensity factors present in the Harvard3 database, with some of the maximum values reaching slightly over 13.

Note that 61686 was assigned a total work value of 6244 in the June 1991 cross specialty scale but was reduced to 5678 in the March 1992 review of the linkages. In May 1992, the Refinement Panel working from a 1992 RVW of 0 recommended a RVW of 48.61 which has resisted subsequent challenges to date. If the original June 1991 work value had been maintained, the current RVW would be approximately 61.20.

SURVEY DATA:

Specialty: Neurological Surgery

61686	Stats	RVW	LOS Days	PRE-SERVICE Time			INTRA TIME Time	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global) Office Visits		
				Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to Reco very O.R. Room Exit	ICU/CCU Visits			Other Hospital Visits (NOT icu/ccu)			Dischg Day Mgmt.	Office Visits after discharge	
											No.x	Time	SUM	No.x	Time	SUM			Time	No.x	Time	SUM
min	35.00	6	15	10	20	240	20	0	2	5	10	3	10	30	15	1	14	14	
25th%	40.00	8	60	15	30	360	20	20	4	15	60	5	15	75	20	2	15	30	
median	42.35	10	75	15	45	420	30	25	5	15	75	7	15	105	30	3	20	60	
75th%	45.00	12	120	20	60	520	40	45	6	25	150	8	15	120	30	4	30	120	
max	103.50	25	180	30	180	600	90	120	14	60	840	26	30	780	45	8	30	240	
survey n	275																		
RVW resp	38																		
rate %	14%																		

CPT Code: 61686

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

The rank order for this series of codes was carefully developed and verified. It provides the basis for revaluation of 61860.

Initial crosswalk or extrapolation misvaluation:

This code was reduced from 6244 total work to 5678 in 1991-1992 crosswalk extrapolation.

Prev. RUC or Refinement Valuation:

These codes were considered at the May92 Refinement Panel but the proposed increases were not accepted.

Time:

Op. Logs:

2 cases: avg. time = 440 min.

Anesthesia databases:

3 cases; avg. anesth. time=321 min.

Harvard3 Database:

Data in the table suggests undervaluation in the Harvard3 database.

Mental Effort & Judgement:

Very high, especially when sustained for several hours.

Technical Skill & Physical Effort:

Among the highest in the specialty.

Stress:

Very high considering the narrow margin between success and disaster during dissection of these delicate vessels.

Intensity/Complexity:

Among the highest in the specialty.

Public Comments

30-Jun-95

Code: 61686 1995 RVUs: 47.45 Recommended RVUs: 56.51 Ratio:

Long Descriptor: Surgery of intracranial arteriovenous malformation; infratentorial, complex

Reference Set (y/n): N Global Period: 090 Frequency: 40 Impact: 362

Source: 7 Year: 94 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis - Beneficiary Information:

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
61686	32	42	14.6

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61686	100	100	0

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
61686	general surgery	4.8
	group practices	9.5
	neurological surgery	85.7

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61686							
	AANS	090	090	57.67	47.45	0.82	0.00

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61686								
AANS	47.45	47.45	0.00		1.00	1.00	56.51	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61686								
AANS	090	57.67						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61686									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61686									
AANS				56.51	47.45	ns	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61690 Global Period: 090 Current RVW: 33.82 Recommended RVW: 27.80

CPT Descriptor: **Surgery of intracranial arteriovenous malformation; dural, complex**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.
AANS recommended a decrease in RVW from 33.82 to 27.80.** Current AANS95 survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42 year old woman has a subarachnoid hemorrhage with a brief period of unconsciousness. A CAT scan shows blood in the basal cisterns and an angiogram shows an aneurysm at the junction of the right vertebral artery with the basilar artery. A far lateral craniectomy is done in the posterior fossa to expose the lesion. The aneurysm is dissected from the parent vessels and a clip placed across the neck.

Description of Pre-Service Work: includes review of the angiogram and imaging studies and appropriate lab studies. Pre-service work includes extensive informed consent with the patient and family, plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup. Positioning is lengthy due to the use of a prone position and stabilization of the patient's head in a pin fixation device.

Description of Intra-Service Work: A scalp flap is outlined and reflected over the mastoid and suboccipital region. After division of the overlying muscles and exposure of the suboccipital bone, the bone is removed to include the margin of the foramen magnum and arch of C1. The dura is opened and retracted, exposing the cerebellum. The aneurysm is exposed by retraction of the anterior and inferior surface of the cerebellum. The vessels are carefully exposed and the neck of the aneurysm is identified. When the neck is exposed and permits application of a clip, the clip is closed across the neck while excluding the adjacent vessels from the clip. After examination to confirm proper clip placement and completion of hemostasis, the dura is closed, the muscle and fascial layers secured, and the scalp closed in layers. A drain may be placed beneath the scalp. Dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of intracranial bleeding or seizures. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS S	Hrvd3 to MFS95	MFS95	Rec. New RVW	Intra Work /min Hrvd3 AANS95
61690	SURGERY OF AV MALFORMATION, DURAL, SIMPLE	232	228		187	3046		30.32	33.82		10.00
61690	SURGERY OF AV MALFORMATION, DURAL, SIMPLE	100	240	40	190		2794			27.80 AANS95	7.28 AANS95
61680	SURGINTRACRAN. ARTERIO-VENOUS MALFORMATION SUPRATENTORIAL, SIMPLE	82	265		184	3562		35.45	36.45		10.60 Hrvd3
61680	SURGINTRACRAN. ARTERIO-VENOUS MALFORMATION, SUPRATENTORIAL, SIMPLE	105	240	38	165		2927			29.13 AANS95	8.61 AANS95
61692	SURGERY OF AV MALFORMATION, DURAL, COMPLEX	97	363		243	4212		41.92	37.96	41.92	8.90 10.51
61692	SURGERY OF AV MALFORMATION, DURAL, COMPLEX	115	340	70	248		4999			48.74 AANS95	10.51 AANS95
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	103	280		256	3470		34.54	34.83		8.68
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	120	270	98	313		4854			48.30 AANS94	12.72 AANS95

CPT Code: 61690

RELATIONSHIP OF 61690 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:
 The proposed new RVWs for this group of procedures are based on rank order valuation supplemented by current survey data for the key reference 61700 and several of the other vascular codes. The justification for the changes is based on the AANS94 and 95 surveys (see Table 1 in Appendix and Survey95 results below). Significant differences between the Harvard3 time data and our Survey95 data are present. There is less pre-service time but slightly more intra-service time in our survey data as well as 40 minutes of ICU time. In addition, the survey specifically obtained an estimate of each of the three components of intensity, along with a rating of the complexity of each phase of the service, pre-, intra- and post-. The survey respondents provided appraisals of the components of intensity for each surveyed service, and the present intensity value listed is a calculated and adjusted average of this same survey data. The survey intensity factor is 7.28 compared to the Harvard3 factor of 10.00. When these intensity differences are applied to the calculation of total work, the Harvard3 value is 3046 while the result from the AANS95 survey is 2794. This translates to a RVW of 27.80 which is our recommended value. The other procedures, 61680 to 61686, are rank ordered around the benchmark 61700, and use of Harvard3 and AANS survey total work comparisons further supports the scaling as indicated..

SURVEY DATA:

Specialty: **Neurological Surgery**

61690	Stats	RVW	LOS	PRE-SERVICE TIME			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
				Hosp Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Opn	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day Mgmt.	Office Visits after discharge				
	min	22.00	4	30	10	25	90	20	10	1	10	10	3	10	30	20	1	15	15
	25th%	30.25	4	35	15	26	190	21	20	2	15	30	3	15	45	20	2	20	40
	Median	31.50	5	48	18	38	248	33	20	2	20	40	4	18	60	30	2	28	66
	75th%	34.19	6	60	20	45	288	40	35	2	28	56	6	20	120	38	3	30	60
	max	36.00	7	120	30	120	300	60	60	4	60	240	6	20	120	45	8	30	240
survey n		275																	
RVW resp		10																	
rate %		4%																	

RATIONALE for recommendation:

Work:
 Rank Order (Ordinal) Valuation: Rank order utilized as described above.
 Initial crosswalk or extrapolation misvaluation: This code was reduced from 3358 total work to 3046 in 1991-1992 crosswalk extrapolation.

Time:
 Harvard3 Database: Data in the table suggests undervaluation in the Harvard3 database.
 Mental Effort & Judgement: Less than 61680 but still fairly high.
 Technical Skill & Physical Effort: Moderately high..
 Stress: High stress level for this entire set of complex vascular codes.
 Intensity/Complexity: Moderately high but the lowest in this family of codes.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61692 Global Period: 090 Current RVW: 37.96 Recommended RVW: 49.74

CPT Descriptor: **Surgery of intracranial arteriovenous malformation; dural, complex**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 37.96 to 49.74. **Current AANS95 survey.**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42 year old woman has a subarachnoid hemorrhage with a brief period of unconsciousness. A CAT scan shows blood in the basal cisterns and an angiogram shows an aneurysm at the junction of the right vertebral artery with the basilar artery. A far lateral craniectomy is done in the posterior fossa to expose the lesion. The aneurysm is dissected from the parent vessels and a clip placed across the neck.

Description of Pre-Service Work: includes review of the angiogram and imaging studies and appropriate lab studies. Pre-service work includes extensive informed consent with the patient and family, plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup. Positioning is lengthy due to the use of a prone position and stabilization of the patient's head in a pin fixation device.

Description of Intra-Service Work: A scalp flap is outlined and reflected over the mastoid and suboccipital region. After division of the overlying muscles and exposure of the suboccipital bone, the bone is removed to include the margin of the foramen magnum and arch of C1. The dura is opened and retracted, exposing the cerebellum. The aneurysm is exposed by retraction of the anterior and inferior surface of the cerebellum. The vessels are carefully exposed and the neck of the aneurysm is identified. When the neck is exposed and permits application of a clip, the clip is closed across the neck while excluding the adjacent vessels from the clip. After examination to confirm proper clip placement and completion of hemostasis, the dura is closed, the muscle and fascial layers secured, and the scalp closed in layers. A drain may be placed beneath the scalp. Dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of intracranial bleeding or seizures. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec. New RVW	Intra Work /min Hrvd3 AANS95
61680	SURGINTRACRAN ARTERIO-VEINUS MALFORMATION, SUPRATENTORIAL, SIMPLE	82	265		184	3562		35.45	36.45		10.60 Hrvd3
61680	SURGINTRACRAN ARTERIO-VEINUS MALFORMATION, SUPRATENTORIAL, SIMPLE	105	240	38	165		2927			29.13 AANS95	8.61 AANS95
61684	SURGINTRACRAN ARTERIO-VEINUS MALFORMATION, INFRATENT, SIMPLE	92	288		206	4015		39.96	39.25	39.96	11.01
61684	SURGINTRACRAN ARTERIO-VEINUS MALFORMATION, INFRATENT, SIMPLE	120	300	45	180		3842		39.25	38.23	9.20 AANS95
61692	SURGERY OF AV MALFORMATION, DURAL, COMPLEX	97	363		243	4212		41.92	37.96	41.92	8.90 10.51
61692	SURGERY OF AV MALFORMATION, DURAL, COMPLEX	115	340	70	248		4998			49.74 AANS95	10.51 AANS95
61702	SURGERY OF INTRACRANIAL ANEURYSM, VERTEBRAL-BASILAR CIRC	78	345		234	4471		44.50	39.20	44.50	10.51 10.98
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	103	280		256	3470		34.54	34.83		8.68
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	120	270	98	313		4854			48.30 AANS94	12.72 AANS95
61682	SURGINTRACRAN ARTERIO-VEINUS MALFORMATION, SUPRATENT, COMPLEX	120	420	60	230		5976		42.21	59.47 AANS95	11.09 AANS95
61686	SURGINTRACRAN ARTERIO-VEINUS MALFORMATION, INFRATENT, COMPLEX	104	505		232	5678		56.51	47.45	56.51	9.35 12.12

CPT Code: 61692

RELATIONSHIP OF 61692 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The proposed new RVWs for this group of procedures are based on rank order valuation supplemented by current survey data for the key reference 61700 and several of the other vascular codes. The justification for the increases is based on the AANS94 and 95 surveys (see Table 1 in Appendix and Survey95 results below). Significant differences between the Harvard3 time data and our Survey95 data are present. There is less intra- and post-service time but more pre-service time in our survey data as well as 70 minutes of ICU time. In addition, the survey specifically obtained an estimate of each of the three components of intensity, along with a rating of the complexity of each phase of the service, pre-, intra- and post-. The survey respondents provided appraisals of the components of intensity for each surveyed service, and the present intensity value listed is a calculated and adjusted average of this same survey data. The survey intensity factor is 10.51 compared to the Harvard3 factor of 8.90. When these intensity differences are applied to the calculation of total work, the Harvard3 value is 4212 while the result from the AANS95 survey is 4999. This translates to a RVW of 49.74 which is our recommended value.

The other procedures, 61680 to 61686, are rank ordered around the benchmark 61700, and use of Harvard3 and AANS survey total work comparisons further supports the scaling as indicated..

The RVW for 61692 is calculated from the AANS95 survey time and work data and places the value between 61680 and the next higher procedure 61692, since it logically falls into that position on a scale of comparative work, mental effort, technical skill, stress and intensity.

The RVW for 61692 is derived from Harvard3 data and places the value between 617684 and the next higher procedure 61702, since it logically falls into that position on a scale of comparative work, mental effort, technical skill, stress and intensity.

Note that 61692 was assigned a total work value of 4621 in the June 1991 cross specialty scale but was reduced to 4212 in the March 1992 review of the linkages. In May 1992, the Refinement Panel working from a 1992 RVW of 0 recommended a RVW of 38.89 which has resisted subsequent challenges to date. If the original June 1991 work value had been maintained, the current RVW would be approximately 45.28.

SURVEY DATA:

Specialty: Neurological Surgery

61692	Stats	RVW	LOS	PRE-SERVICE TIME			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)						
				Time	Time	Time		Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time
			Hosp Stay	Eval. before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	SUM	Other Hospital Visits (NOT icu/ccu)	Dischg Day Mgmt.	Office Visits after discharge						
	min	34.00	6	30	10	25	270	20	0	2	15	30	4	10	40	4	1	15	15	
	25th%	34.49	7	46	15	33	300	30	20	3	16	49	4	15	64	25	2	23	45	
	median	35.50	7	55	15	45	340	35	30	4	20	70	6	15	90	35	2	30	60	
	75th%	39.21	12	68	20	60	405	44	44	5	28	141	7	20	135	38	4	30	113	
	max	48.00	12	140	30	180	480	80	80	6	60	360	18	20	360	45	8	30	240	
survey n		275																		
RVW resp		10																		
rate %		4%																		

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Rank order utilized as described above.

Initial crosswalk or extrapolation misvaluation:

This code was reduced from 4621 total work to 4212 in 1991-1992 crosswalk extrapolation.

Prev. RUC or Refinement Valuation:

These codes were considered at the May92 Refinement Panel but the proposed increases were not accepted.

Time:

Anesthesia databases:

3 cases; avg. anesth. time=321 min.

Harvard3 Database:

Data in the table suggests undervaluation in the Harvard3 database.

Mental Effort & Judgement:

Very high, especially when sustained for several hours.

Technical Skill & Physical Effort:

Among the highest in the specialty.

Stress:

High stress level for this entire set of complex vascular codes.

Intensity/Complexity:

Very high.

Public Comments

30-Jun-95

Code: 61692 **1995 RVUs:** 37.96 **Recommended RVUs:** 41.92 **Ratio:**

Long Descriptor: Surgery of intracranial arteriovenous malformation; dural, complex

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 13 **Impact:** 51

Source: 7 **Year:** 94 **Public Comment Letter:** 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61692	18	12	-18.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61692	100	100	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61692	neurological surgery	66.7
	neurology	33.3

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61692							
	AANS	090	090	42.78	37.96	0.89	0.00

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61692								
AANS	37.96	37.96	0.00		1.00	1.00	41.92	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61692								
AANS	090	42.78						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61692									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61692									
AANS				41.92	37.96	ns	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61700 Global Period: 090 Current RVW: 34.83 Recommended RVW: 48.30

CPT Descriptor: **Surgery of intracranial aneurysm, intracranial approach; carotid circulation**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on Key Reference Procedure.**
AANS recommended an increase in RVW from 34.83 to 48.30.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Hrwd3 Intra Work/min
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec.New RVW	
61680	SURG/INTRACRAN ARTERIO-VEINUS MALFORMATION SUPRATENTORIAL SIMPLE	82	265		184	3562		35.45	36.45	38.20	10.60
61684	SURG/INTRACRAN ARTERIO-VEINUS MALFORMATION INFRATENT SIMPLE	92	288		206	4015		39.96	39.25	39.96	11.01
61692	SURGERY OF AV MALFORMATION, DURAL COMPLEX	97	363		243	4212		41.92	37.96	41.92	8.90
61702	SURGERY OF INTRACRANIAL ANEURYSM, VERTEBRAL-BASILAR CIRC	78	345		234	4471		44.50	39.20	44.50	10.32
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	103	280		256	3470		34.54	34.83		8.68
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC	120	270	98	215	4854		34.83	48.30	48.30	12.72
61682	SURG/INTRACRAN ARTERIO-VEINUS MALFORMATION SUPRATENT COMPLEX	96	446		225	5156		51.32	42.21	51.32	9.50
61686	SURG/INTRACRAN ARTERIO-VEINUS MALFORMATION INFRATENT COMPLEX	104	505		232	5678		56.51	47.45	56.51	9.35

RELATIONSHIP OF 61700 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The proposed new RVWs for this group of procedures are based on rank order valuation supplemented by current survey data for the key reference 61700 and several of the other vascular codes. The justification for the increases is based on the AANS94 and 95 surveys (see Table 1 in Appendix). Measurements of significantly increased Pre- and Post-service times (+37%), plus an average of 5 days of ICU time for these patients is noted. When this additional time is entered into the calculation of work, the AANS94 survey generates a total work value of 3764 compared to the Harvard3 total work of 3471. When the additional change of an increase in the intensity factor for 61700 is included in the calculation, the total work value reaches 4854. When this is converted into RVWs (1995), it increases the total work RVWs to the recommended value of 48.30.

Note that the increase in intensity (work/minutes of intra-service time) from the Harvard3 value of 8.68 to the survey value of 12.72 is a dramatic shift. The Harvard3 value was calculated as described in the introduction and in Appendix D which introduced factors that had very little to do with the mental effort, technical skill and stress involved in this service. The survey specifically requested an estimation of each of these components of intensity, along with a rating of the complexity of each phase of the service, pre-, intra- and post-. The 101 respondents to the survey ranked 61700 with the highest intensity and complexity values of any service examined, and that is clearly more representative of the relative intensity among this family of services than the values listed in the table from Harvard3. The present value is a calculated and adjusted average of the survey data.

The other procedures, 61680 to 61686, are rank ordered around the benchmark 61700, and use of Harvard3 total work comparisons further supports the scaling as indicated. All but 61680 have recommended RVWs based on the Harvard3 database as converted to the 1995 MFS values, and all have comparable Pre- and Post-service time increases over the Harvard3 benchmark valuation. The time data for Pre- and Post-service times for these four codes listed in the Harvard3 database are all undervalued based on the time compression analysis described in the introduction. The amount of the time/work compression is apparent from the substantially higher total work values surveyed and the higher RVWs as listed.

CPT Code: 61700

SURVEY DATA:

Specialty: **Neurological Surgery**

CPT 61700	Stats	LOS	PRE-SERVICE TIME			INTRA TIME	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global)		
			Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Ext	Recovery Room	ICU/CCU Visits		Other Hospital Visits (NOT icu/ccu)		Dischg Day Mgmt.	Office Visits after discharge		
				Time	Time		Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM
	min	5	15	10	9	120	5	0	0	0	0	2	5	15	10	1	10	30
	25th%	8	45	15	30	240	15	15	4	15	60	4	10	49	20	3	15	45
	median	10	60	15	45	270	20	25	5	15	98	6	15	80	30	4	15	60
	75th%	14	90	15	60	300	30	30	8	20	210	8	15	120	30	4	20	76
	max	25	240	35	100	400	70	180	15	60	450	21	30	320	75	10	60	180
Intra-time #	101																	
Sample #																		
% response	48%																	

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

The rank order for this series of codes was carefully developed and verified. It provides the basis for revaluation of 61860.

Initial crosswalk or extrapolation misvaluation:

This code was increased from 3458 total work to 3470 in 1991-1992 crosswalk extrapolation.

Prev. RUC or Refinement Valuation:

These codes were considered at the May92 Refinement Panel but the proposed increases were not accepted.

Time:

Op. Logs:

7 cases; avg. intra- time=274 min.

Anesthesia databases:

241 cases, avg. anesth. time = 349 min.

AANS94 Survey Key Refs:

See data table above.

Harvard3 Database:

Data in the table suggests undervaluation in the Harvard3 database.

Undervalued time/Phase I or II & MFS92:

Initial undervaluation to lesser degree than others in family.

Mental Effort & Judgement:

Very high, especially when sustained for several hours.

Technical Skill & Physical Effort:

Among the highest in the specialty.

Stress:

Very high considering the narrow margin between success and disaster during dissection of these delicate vessels.

Intensity/Complexity:

Very high. See comments above.

Public Comments

30-Jun-95

Code: 61700 1995 RVUs: 34.83 Recommended RVUs: 37.45 Ratio:

Long Descriptor: Surgery of intracranial aneurysm, intracranial approach; carotid circulation

Reference Set (y/n): Y Global Period: 090 Frequency: 2.216 Impact: 5806

Source: 4 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61700	30.8	1.5	20.6	72.3	18.5	1.5	0	9.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61700	2452	2551	2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61700	98.2	98.9	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61700	group practices	3.6
	neurological surgery	93.1
	neurology	2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61700	331	1.2	OTHER CEREBRAL DEGENERATIONS
	430	10.8	SUBARACHNOID HEMORRHAGE
	431	2.3	INTRACEREBRAL HEMORRHAGE
	437	9.2	OTHER AND ILL-DEFINED CEREBROVAS

Public Comments

30-Jun-95

442	3.1	OTHER ANEURYSM
747	2.3	OTHER CONGENITAL ANOMALIES OF CI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61700							
AANS		090	090	35.25	34.83	0.99	34.83

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61700								
AANS	34.83	34.83	0.99	1.00	1.00	1.00	37.45	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61700								
AANS	090	35.25		57		280		74

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61700									
AANS		1.5		10	12.0		15	1.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61700									
AANS		15		37.45	34.83	ns	n		0.088

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61702 Global Period: 090 Current RVW: 39.20 Recommended RVW: 46.31

CPT Descriptor: **Surgery of intracranial aneurysm, intracranial approach; vertebral-basilar circulation**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 39.20 to 46.31. **Current AANS95 survey.**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42 year old woman has a subarachnoid hemorrhage with a brief period of unconsciousness. A CAT scan shows blood in the basal cisterns and an angiogram shows an aneurysm at the junction of the right vertebral artery with the basilar artery. A far lateral craniectomy is done in the posterior fossa to expose the lesion. The aneurysm is dissected from the parent vessels and a clip placed across the neck.

Description of Pre-Service Work: includes review of the angiogram and imaging studies and appropriate lab studies. Pre-service work includes extensive informed consent with the patient and family, plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup. Positioning is lengthy due to the use of a prone position and stabilization of the patient's head in a pin fixation device.

Description of Intra-Service Work: A scalp flap is outlined and reflected over the mastoid and suboccipital region. After division of the overlying muscles and exposure of the suboccipital bone, the bone is removed to include the margin of the foramen magnum and arch of C1. The dura is opened and retracted, exposing the cerebellum. The aneurysm is exposed by retraction of the anterior and inferior surface of the cerebellum. The vessels are carefully exposed and the neck of the aneurysm is identified. When the neck is exposed and permits application of a clip, the clip is closed across the neck while excluding the adjacent vessels from the clip. After examination to confirm proper clip placement and completion of hemostasis, the dura is closed, the muscle and fascial layers secured, and the scalp closed in layers. A drain may be placed beneath the scalp. Dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of intracranial bleeding or seizures. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec. New RVW	
61680	SURG/INTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENTORIAL, SIMPLE	82	265		184	3562		35.45	36.45		10.60 Hrvd3
61680	SURG/INTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENTORIAL, SIMPLE	105	240	38	165		2927			29.13 AANS95	8.61 AANS95
61684	SURG/INTRACRAN. ARTERIO-VEINUS MALFORMATION, INFRATENT. SIMPLE	92	288		206	4015		39.96	39.25	39.96	11.01 9.20
61692	SURGERY OF AV MALFORMATION, DURAL, COMPLEX	97	363		243	4212		41.92	37.96	41.92	8.90 10.51
61702	SURGERY OF INTRACRANIAL ANEURYSM VERTEBRAL-BASILAR CIRC	78	345		234	4471		44.50	39.20		10.51
61702	SURGERY OF INTRACRANIAL ANEURYSM, VERTEBRAL-BASILAR CIRC.	120	300	60	240		4654			46.31	10.98
61700	SURGERY OF INTRACRANIAL ANEURYSM INTRACRANIAL CAROTID CIRC	103	280		256	3470		34.54	34.83		8.68
61700	SURGERY OF INTRACRANIAL ANEURYSM, INTRACRANIAL CAROTID CIRC.	120	270	98	313		4854			48.30 AANS94	12.72 AANS95
61682	SURG/INTRACRAN. ARTERIO-VEINUS MALFORMATION, SUPRATENT. COMPLEX	120	420	60	230		5976		42.21	59.47 AANS96	11.09
61686	SURG/INTRACRAN. ARTERIO-VEINUS MALFORMATION, INFRATENT. COMPLEX	104	505		232	5678		56.51	47.45	56.51	9.35 12.12

CPT Code: 61702

RELATIONSHIP OF 61702 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The proposed new RVWs for this group of procedures are based on rank order valuation supplemented by current survey data for the key reference 61700 and several of the other vascular codes. The justification for the increases is based on the AANS94 and 95 surveys (see Table 1 in Appendix). Measurements of significantly increased Pre- and Post-service times (+37%), plus an average of 5 days of ICU time for these patients is noted. When this additional time is entered into the calculation of work, the AANS94 survey generates a total work value of 4654 compared to the Harvard3 total work of 4471. When the additional change of an increase in the intensity factor for 61702 is included in the calculation, the total work value reaches 4854. When this is converted into RVWs (1995), it increases the total work RVWs to the recommended value of 46.31.

The other procedures, 61680 to 61686, are rank ordered around the benchmark 61700, and use of Harvard3 total work comparisons further supports the scaling as indicated. All but 61680 have recommended RVWs based on the AANS95 survey data as converted to the 1995 MFS values, and all have comparable Pre- and Post-service time increases over the Harvard3 benchmark valuation. The time data for Pre- and Post-service times for these four codes listed in the Harvard3 database are all undervalued based on the time compression analysis described in the introduction. Consequently, use of the AANS95 RVWs as translated to the MFS95 are proposed as appropriate to the rank order within this family of intracranial vascular code RVWs.

The RVW and total work for 61702 as surveyed is lower than that for a carotid aneurysm, 61700. The basis for this difference lies in the larger amount of ICU and post-service time surveyed for 61700, plus a higher intensity factor than 61702. This probably reflects a trend for many neurosurgeons to refer basilar aneurysm patients to centers with sufficient experience with these lesions to provide a higher level of care, and thence enjoy time-saving protocols that occur in such settings.

The RVW for 61702 is calculated from Harvard3 time data to place the value between 61692 and the next higher procedure 61682, since it logically falls into that position on a scale of comparative work, mental effort, technical skill, stress and intensity. Note that 61702 was assigned a total work value of 4901 in the June 1991 cross specialty scale but was reduced to 4471 in the March 1992 review of the linkages. In May 1992, the Refinement Panel working from a 1992 RVW of 0 recommended a RVW of 40.16 which has resisted subsequent challenges to date. If the original June 1991 work value had been maintained, the current RVW would be approximately 48.02.

SURVEY DATA:

Specialty: Neurological Surgery

61702	Stats	RVW	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
			Hosp. Stay	Eval. before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day Mgmt.	Office Visits after discharge						
			Days	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM	
	min	30.00	6	30	10	15	100	10	0	2	5	10	3	10	30	15	1	15	15
	25th%	37.25	8	60	15	30	300	20	20	3	15	45	4	10	40	20	2	15	30
	median	38.18	10	60	15	45	300	30	30	4	15	60	6	15	90	30	3	20	60
	75th%	43.75	14	90	20	60	360	40	45	9	20	180	10	15	150	30	4	30	120
	max	70.00	38	180	40	180	600	90	120	27	40	1080	40	20	800	60	8	30	240
Survey n	275																		
RVW resp	38																		
rate %	14%																		

CPT Code: 61702

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

The rank order for this series of codes was carefully developed and verified. It provides the basis for revaluation of 61860.

Initial crosswalk or extrapolation misvaluation:

This code was reduced from 4901 total work to 4471 in 1991-1992 crosswalk extrapolation.

Prev. RUC or Refinement Valuation:

These codes were considered at the May92 Refinement Panel but the proposed increases were not accepted.

Time:

Op. Logs:

4 cases; avg. time = 463 min.

Anesthesia databases:

11 cases; avg. anesth. time=328 min.

Harvard3 Database:

Data in the table suggests undervaluation in the Harvard3 database.

Mental Effort & Judgement:

Very high, especially when sustained for several hours.

Technical Skill & Physical Effort:

Among the highest in the specialty.

Stress:

Very high considering the narrow margin between success and disaster during dissection of these delicate vessels.

Intensity/Complexity:

Very high.

Public Comments

30-Jun-95

Code: 61702

1995 RVUs: 39.2

Recommended RVUs: 44.50

Ratio:

Long Descriptor: Surgery of intracranial aneurysm, intracranial approach; vertebral-basilar circulation

Reference Set (y/n): N Global Period: 090 Frequency: 202 Impact: 1071

Source: 5 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61702	0	0	25	25	75	0	0	25

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61702	248	238	-2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61702	97.6	100	1.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61702	group practices	6.7
	neurological surgery	92.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61702	342	6.3	HEMIPLEGIA
	430	6.3	SUBARACHNOID HEMORRHAGE
	437	6.3	OTHER AND ILL-DEFINED CEREBROVAS
	747	6.3	OTHER CONGENITAL ANOMALIES OF CI
	780	6.3	GENERAL SYMPTOMS

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packlv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61702							
AANS		090	090	45.41	39.20	0.86	0.00

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61702								
AANS	39.20	39.20	0.00		1.00	1.00	44.50	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61702								
AANS	090	45.41						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61702									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61702									
AANS				44.50	39.20	ns	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61720 Global Period: 090 Current RVW: 15.85 Recommended RVW: 15.92

CPT Descriptor: Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended increase in RVW from 15.85 to 15.92.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 61 year old male with a history of Parkinsons disease and severe right sided tremor. unresponsive to medications. A radiofrequency lesion is made in the thalamus to reduce the tremor.

Description of Pre-Service Work: includes review of previous medical records, evaluation of the imaging studies, and appropriate lab and screening studies. Pre-service work includes informed consent with the patient and family. Positioning is more complex due to the use of a stereotactic frame that requires coordinate indexing to the patient table.

Description of Intra-Service Work: The intra-service work begins with the application of the stereotactic head frame under local anesthesia. The patient is then transported to Radiology where stereotactic imaging studies are obtained. This may be either MRI or CT scanning. The neurosurgeon must position and secure the patient on the imaging table and attach an appropriate stereotactic localizer. He then works with a radiologist or technician to identify the precise areas to be imaged by adjustment of the scanning geometry. Finally, the neurosurgeon verifies that the target is optimally imaged. The patient is then returned to the operating room, still in the frame, and the surgery is begun. A scalp incision is made at an appropriate site for entry of the radiofrequency probe, a burr hole made, and the probe inserted into the stereotactic guide. After confirmation of the desired coordinates, the probe is introduced into the brain to the target depth. A radiofrequency lesion is then made and the patient's tremor checked. Additional radiofrequency lesioning may be delivered depending on the patient's response. When completed, the probe is removed and the scalp would sutured. Dressings are applied. Removal of the frame is done at the end of the service period.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of complications. The hospital visits and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Work/mln Hrvd3 AANS
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	
61796	STEREOTACTIC LESION, PERCUTAN /GASSERIAN GANGLION	69	82		79	1010		10.05	10.31		7.85
61791	STEREOTACTIC LESION, PERCUTAN /TRIGEMINAL MEDULLARY TRACT	68	119		85	1406		13.99	7.29	13.99	8.60
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	75	186		186	1882		18.73	15.85		6.13
61720	CREATION STEREOTACTIC LESION GLOBUS PALLIDUS OR THALAMUS	105	120	13	120		1600			15.92 AANS96	7.61 AANS95
61750	STEREOTACTIC BIOPSY ASP OR EXCIS OF INTRACRANIAL LESION	70	133		169	1675		16.67	10.03	16.67	7.52
61751	STEREOTACTIC BIOPSY, ASP, OR EXCIS, OF LESION W COMPUTERIZED AXIAL TOMO	75	185	10	125		1674			16.66 *****	5.95 AANS94
61735	CREATION SUBCORTICAL LESION/STEREOTACTIC METHOD	75	184		186	1881		18.72	17.08	18.72	6.20
61770	STEREOTACTIC LOCALIZATION W INSERTION OF CATHETERS/BRACHTHERAPY	71	140		183	1987		19.78	15.14	19.78	8.96

CPT Code 61720

RELATIONSHIP OF 61720 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) is the reference service for this group of procedures. They have in common the use of stereotactic localization techniques to target a deep intracranial structure for purposes of biopsy, incision, stimulation, or destruction by either radiation or radiofrequency or injection. The reference procedure 61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) has a total work value of 1010 and a time of 82 minutes with a RVW of 10.31. This represents a close translation of the Harvard3 time and work data to the present MFS value for work. The comparable values for the remainder of the procedures in this family are tabulated above for comparison, and the procedures are arranged in ascending rank order for work, using the Harvard3 database for anchor points. We recommend the RVWs listed in the right column for this set of procedures.

In the case of 61720 (CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS), this service is designed to ameliorate the tremor of patients with Parkinsonism. It involves more time, skill and risk than 61790. The Harvard3 time and work values appear appropriate in relation to the other procedures listed. However, the data from our survey show substantially less intra- and post-service time, a single ICU visit, and a total work value of 1600 compared to the Harvard3 total work of 1882. The shorter intra- and post-service times (of up to one hour) combine to reduce the total work, despite a slightly greater intensity for the survey responses (7.61) compared to the Harvard3 intensity of 6.13. When the 1600 work value is converted to the scale of the MFS95, the recommended RVW is 15.92.

SURVEY DATA:

Specialty: Neurological Surgery

61720	Stats	RVW	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS							OFFICE VISITS (thru global)					
				Days	Time	Time		Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM
min	17.08	1	25	5	10	40	5	0	0	0	0	1	10	10	10	1	15	15		
25th%	19.00	2	56	14	24	90	10	10	0	0	0	2	15	26	15	2	15	30		
median	22.72	2	80	15	30	120	15	20	1	13	13	2	15	30	26	2	18	36		
75th%	26.00	3	120	15	49	180	20	20	1	15	15	2	15	30	30	3	20	60		
max	35.00	4	180	30	150	360	30	120	2	30	60	6	30	180	45	6	30	180		
survey n	275																			
RVW resp	21																			
rate %	8%																			

RATIONALE for recommendation:

Work:

Changes in past 5 years:

Reduced times reflect increased familiarity with the stereotactic technology in the centers providing this service compared to 5-10 years ago.

Rank Order (Ordinal) Valuation:

Ordinal values appropriate as listed in table of reference service 5/92 refinement panel increased RVW from 10.92 to 16.24.

Prev. RUC or Refinement Valuation:

Time:

AANS95 Survey:

Data included in tables above.

Harvard3 Database:

Time and work values appear high relative to both Refinement panel and AANS95 survey data.

Mental Effort & Judgement:

More mental effort and judgment than 61790

Technical Skill & Physical Effort:

Greater skill than 61790

Stress:

Risk factors higher

Intensity/Complexity:

Complexity somewhat greater, working at depth in the brain.

Public Comments

30-Jun-95

Code: 61720 1995 RVUs: 15.85 Recommended RVUs: 18.73 Ratio:

Long Descriptor: Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus

Reference Set (y/n): N Global Period: 090 Frequency: 342 Impact: 985

Source: 5 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61720	33.3	0	0	25	16.7	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61720	160	356	49.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61720	93.1	96.6	1.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61720	group practices	6.7
	neurological surgery	87.6
	neurology	3.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61720	332	20.8	PARKINSON'S DISEASE
	781	2.1	SYMPTOMS INVOLVING NERVOUS AND

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61720							
AANS		090	090	19.12	15.85	0.83	10.37

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61720								
AANS	15.85	15.85	0.54	1.53	1.00	1.00	18.73	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61720								
AANS	090	19.12		39	*	186		

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61720									
AANS		1.0	*	10	10.5	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61720									
AANS	*	15		18.73	15.85	ns	3		0.062

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
Comments on Misvalued Code**

CPT Code: 61735 Global Period: 090 Current RVW: 17.08 Recommended RVW: 18.72

CPT Descriptor: **Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; subcortical structure(s) other than globus pallidus or thalamus**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 17.08 to 18.72.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec. New RVW	
61798	STEREOTACTIC LESION, PERCUTAN /GASSERIAN GANGLION	69	82		79	1010		10.05	10.31		7.85
61791	STEREOTACTIC LESION, PERCUTAN /TRIGEMINAL MEDULLARY TRACT	68	119		85	1406		13.99	7.29	13.99	8.60
61720	CREATION STEREOTACTIC LESION GLOBUS PALLIDUS OR THALAMUS	75	186		186	1882		18.73	15.85		6.13
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	105	120	13	120		1600			15.92 AANS95	7.61 AANS95
61750	STEREOTACTIC BIOPSY, ASP OR EXCIS. OF INTRACRANIAL LESION	70	133		169	1675		16.67	10.03	16.67	7.52
61751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO	75	187		185	1838		18.29	15.18 Hrvd3		5.88
61751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO	138	90	10	173		1392			13.85 AANS94	5.95 AANS94
61751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO	75	185	10	125		1674			16.86 *****	5.95 AANS94
61735	CREATION SUBCORTICAL LESION/STEREOTACTIC METHOD	75	184		186	1881		18.72	17.08	18.72	6.20
61770	STEREOTACTIC LOCALIZATION W INSERTION OF CATHETERS/BRACHYTHERAPY	71	140		183	1987		19.78	15.14	19.78	8.96

CPT Code: 61735

RELATIONSHIP OF 61735 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) is the reference service for this group of procedures. They have in common the use of stereotactic localization techniques to target a deep intracranial structure for purposes of biopsy, incision, stimulation, or destruction by either radiation or radiofrequency or injection. The reference procedure 61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) has a total work value of 1010 and a time of 82 minutes with a RVW of 10.31. This represents a close translation of the Harvard3 time and work data to the present MFS value for work. The comparable values for the remainder of the procedures in this family are tabulated above for comparison, and the procedures are arranged in ascending rank order for work, using the Harvard3 database and the AANS94 & 95 survey data for reference. We recommend the RVWs listed in the right column for this set of procedures.

In the case of 61735 (CREATION OF SUBCORTICAL LESION, STEREOTACTIC METHOD), this service is designed to ameliorate pain in patients with intractable pain problems. It involves more time, skill and risk than 61790, and the Harvard3 time and work values appear appropriate in relation to the other procedures listed. We recommend a RVW of 18.72.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Ordinal values appropriate as listed in table of reference service

Prev. RUC or Refinement Valuation:

5/92 Refinement panel increased RVW92 from 12.32 to 17.50.

Time:

Harvard3 Database:

Time and work data appear reasonable.

Undervalued time/Phase I or II & MFS92:

All codes above 61790 undervalued re: Harvard3 data.

Mental Effort & Judgement:

More mental effort and judgment than 61790

Technical Skill & Physical Effort:

Greater skill than 61790

Stress:

Risk factors higher

Intensity/Complexity:

Complexity somewhat greater, working at depth in the brain.

Public Comments

30-Jun-95

Code: 61735**1995 RVUs:** 17.08**Recommended RVUs:** 18.72**Ratio:****Long Descriptor:** Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; subcortical structure(s) other than globus pallidus or thalamus**Reference Set (y/n):** N **Global Period:** 090 **Frequency:** 27 **Impact:** 44**Source:** 5 **Year:** 93 **Public Comment Letter:** 340**Reference Services:****CMD Comment:**

Societies Wishing to Survey: AANS**Societies Wishing to Comment:****Trends Analysis -- Beneficiary Information:****Trends Analysis -- Frequency:**

	QX92	QX94	Chg92_94
61735	24	32	15.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61735	91.7	100	4.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61735	general/family practice	6.3
	group practices	12.5
	neurological surgery	81.3

Claims-Level Diagnosis Information:**Harvard Data:**

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61735							

Public Comments

30-Jun-95

AANS	090	090	19.11	17.08	0.89	11.69
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61735								
AANS	17.08	17.08	0.61	1.46	1.00	1.00	18.72	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61735								
AANS	090	19.11		39	*	184		

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61735									
AANS		1.0	*	10	10.5	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61735									
AANS	*	15		18.72	17.08	ns	3		0.063

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61750 Global Period: 090 Current RVW: 10.03 Recommended RVW: 16.67

CPT Descriptor: **Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 10.03 to 16.67.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	Work/mia Hrvd3 AANS
61790	STEREOTACTIC LESION, PERCUTAN/GASSERIAN GANGLION	69	82		79	1010		10.05	10.31		7.85
61791	STEREOTACTIC LESION, PERCUTAN/TRIGEMINAL MEDULLARY TRACT	68	119		85	1406		13.99	7.29	13.99	8.60
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	75	186		186	1882		18.73	15.85		6.13
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	105	120	13	120		1600			15.92 AANS95	7.61 AANS95
61751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO	75	187		185	1838		18.29	15.18 Hrvd3		5.88
61751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO	138	90	10	173		1392			13.85 AANS94	5.95 AANS94
61751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO	76	185	10	125		1674			16.66 AANS94	5.96 AANS94
61750	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF INTRACRANIAL LESION	70	133		169	1675		16.67	10.03	16.67	7.52
61735	CREATION SUBCORTICAL LESION/STEREOTACTIC METHOD	75	184		186	1881		18.72	17.08	18.72	6.20
61770	STEREOTACTIC LOCALIZATION W INSERTION OF CATHETERS/BRACHTHERAPY	71	140		183	1987		19.78	15.14	19.78	8.96

RELATIONSHIP OF 61750 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) is the reference service for this group of procedures. They have in common the use of stereotactic localization techniques to target a deep intracranial structure for purposes of biopsy, incision, stimulation, or destruction by either radiation or radiofrequency or injection. The reference procedure 61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) has a total work value of 1010 and a time of 82 minutes with a RVW of 10.31. This represents a close translation of the Harvard3 time and work data to the present MFS value for work. The comparable values for the remainder of the procedures in this family are tabulated above for comparison, and the procedures are arranged in ascending rank order for work, using the Harvard3 database for anchor points. We recommend the RVWs listed in the right column for this set of procedures.

In the case of 61750 (STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF INTRACRANIAL LESION), this service is used to biopsy lesions in patients with tumors in deep seated cerebral structures. It involves more time, skill and risk than 61790. The intra-service time is 51 minutes greater and the post-service time 90 minutes more than 61790. The Harvard3 total work value appears appropriate in relation to the other procedures listed. We recommend a RVW of 16.67.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation: Ordinal values appropriate as listed in table of reference service
Prev. RUC or Refinement Valuation:

Time:

Anesthesia databases: 98 cases; avg. anesth. time= 170 min.

Mental Effort & Judgement: More mental effort and judgment than 61790

Technical Skill & Physical Effort: Greater skill than 61790

Stress: Risk factors higher

Intensity/Complexity: Complexity somewhat greater, working at depth in the brain.

Public Comments

30-Jun-95

Code: 61750 1995 RVUs: 10.03 Recommended RVUs: 16.67 Ratio:

Long Descriptor: Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion;

Reference Set (y/n): N Global Period: 090 Frequency: 623 Impact: 4137

Source: 4 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61750	33.3	6.7	13.3	66.7	6.7	0	0	6.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61750	691	829	9.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61750	97.1	97.3	0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61750	anesthesiology	25.6
	group practices	7
	neurological surgery	64.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61750	191	8.3	MALIGNANT NEOPLASM OF BRAIN
	225	1.7	BENIGN NEOPLASM OF BRAIN AND OTH
	237	1.7	NEOPLASM OF UNCERTAIN BEHAVIOR O
	239	5	NEOPLASMS OF UNSPECIFIED NATURE

Public Comments

30-Jun-95

324	1.7	INTRACRANIAL AND INTRASPINAL ABS
348	1.7	OTHER CONDITIONS OF BRAIN
431	1.7	INTRACEREBRAL HEMORRHAGE
436	1.7	ACUTE, BUT ILL-DEFINED, CEREBROVAS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61750							
AANS		090	090	17.01	10.03	0.59	10.03

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61750								
AANS	10.03	10.03	0.59	1.00	1.00	1.00	16.67	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notatt	Imppt
61750								
AANS	090	17.01		35	*	133		

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdviadur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61750									
AANS		10	*	10	9.5	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61750									
AANS	*	15		16.67	10.03	ns	3		0.076

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 61751 Global Period: 090 Current RVW: 15.18 Recommended RVW: 16.66

CPT Descriptor: Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computerized axial tomography

Source and Summary of Comment to HCFA on this service: Public Comments by AANS on Key Reference Procedures. AANS recommended an increase in RVW from 15.18 to 16.66 based on an analysis of survey and other data.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old male with progressive left hemiparesis and a CT scan that shows a ring enhancing lesion in the right thalamus. A stereotactic biopsy of this single lesion is done through a burr hole under sedated local anesthesia.

Description of Pre-Service Work: includes review of previous medical records, evaluation of the imaging studies, and appropriate lab and screening studies. Pre-service work includes informed consent with the patient and family. Positioning is more complex due to the use of a stereotactic frame that requires coordinate indexing to the patient table.

Description of Intra-Service Work: The intra-service work begins with the application of the stereotactic head frame under local anesthesia. The patient is then transported to Radiology where stereotactic imaging studies are obtained. This may be either MRI or CT scanning. The neurosurgeon must position and secure the patient on the imaging table and attach an appropriate stereotactic localizer. He then works with a radiologist or technician to identify the precise areas to be imaged by adjustment of the scanning geometry. Finally, the neurosurgeon verifies that the target is optimally imaged including appropriate use of enhancement dosages. The patient is then returned to the operating room, still in the frame, and the surgery is begun. A scalp incision is made at an appropriate site for entry of the biopsy probe, a burr hole made, and the probe inserted into the stereotactic guide. After confirmation of the desired coordinates, the probe is introduced into the brain to the target depth. A series of biopsy specimens are then obtained and reviewed by the pathologist. Additional samples may be obtained depending on the pathologist's input. When completed, the probe is removed and the scalp would be sutured. Dressings are applied. Removal of the frame is done at the end of the service period.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of complications and hemorrhage. The hospital visits and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	Work/mia Hrvd3 AANS
61788	STEREOTACTIC LESION, PERCUTAN /GASSERIAN GANGLION	69	82		79	1010		10.05	10.31		7.85
61791	STEREOTACTIC LESION PERCUTAN /TRIGEMINAL MEDULLARY TRACT	68	119		85	1406		13.99	7.29	13.99	8.60
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	75	186		186	1882		18.73	15.85		6.13
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	105	120	13	120		1600			15.92 AANS95	7.61 AANS95
61751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO	75	187		185	1838		18.29	15.18 Hrvd3		5.88
61751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO	138	90	10	173		1392			13.85 AANS94	5.95 AANS94
61751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO	75	185	10	125		1674			16.66 *****	5.95 AANS94
61750	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF INTRACRANIAL LESION	70	133		169	1675		16.67	10.03	16.67	7.52
61735	CREATION SUBCORTICAL LESION/STEREOTACTIC METHOD	75	184		186	1881		18.72	17.08	18.72	6.20
61770	STEREOTACTIC LOCALIZATION W INSERTION OF CATHETERS/BRACHTHERAPY	71	140		183	1987		19.78	15.14	19.78	8.96

***** see below

PT Code: 61751

RELATIONSHIP OF 61751 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) is the reference service for this group of procedures. They have in common the use of stereotactic localization techniques to target a deep intracranial structure for purposes of biopsy, incision, stimulation, or destruction by either radiation or radiofrequency or injection. The reference procedure 61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) has a total work value of 1010 and a time of 82 minutes with a RVW of 10.05. This procedure represents the process of introducing a needle through the skin of the face and directing it to enter the foramen ovale in the floor of the middle cranial fossa to then enter the Gasserian ganglion immediately posterior to this root of the trigeminal nerve. The purpose is to permit injection of a neurolytic material that will interfere with the pain mechanism of trigeminal neuralgia. The stereotactic aspect of this service simply represents the use of x-ray imaging during the course of needle insertion and positioning to aid in entry of the ganglion. Usually this is done with bi-plane x-rays or fluoroscopy of the patients head to use the bony basal landmarks to augment the needle guidance. It does not regularly include use of a stereotactic frame and tomographic targeting so the additional time and work of that service is not included in 61790. The Harvard3 RVW of 10.05 represents a close approximation to the current MFS95 RVW of 10.31 which appears to reflect a fair representation of the work of this reference service. The comparable values for the remainder of the procedures in this family are tabulated above for comparison, and the procedures are arranged in ascending rank order for work, using the Harvard3 database for anchor points. We recommend the boldface RVWs listed in the right column for this set of procedures.

In the case of 61751 (STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO), this service is used to biopsy or excise lesions in patients with tumors in deep seated cerebral structures utilizing the CT or MRI scan with the patient in a head frame to develop coordinates for targeting. It involves more time, skill and risk than 61790. The Harvard3 work value appears appropriate in relation to the other procedures listed but does not conform to the calculation of work and RVW based on the AANS94 survey data. That survey data gives a total work value of 1392 (on the scale of Harvard3) which translates to a RVW of 13.85. The principal differences are in a much shorter intra-service time (and work) for the AANS94 survey, amounting to less than 50% or the Harvard3 intra-service time. This shorter time is also reflected in the op. logs and anesthesia time databases listed below, both of which indicate intra-service times in the range of 90 minutes rather than the 187 minutes from Harvard3. We believe that this represents a major underestimation of the intra-service time, since a piecemeal reconstruction of the intra-service components comes much closer to the higher Harvard3 time of 187 minutes.

To illustrate this difference, the steps involved in 61751 with their associated times for an average case are listed as follows:

Application of stereotactic head frame after local anesthetic injected into scalp or induction general anesthesia	30 min
Transport of patient with frame attached to the CT facility and placement on the scanner table	15 min
Connect frame to indexing attachment on CT table and align to scanner geometry	10 min
Select suitable axis for scan, administer contrast to patient, identify the target and complete scans	20 min
Remove patient from CT table and transport to OR and while coordinates plotted	15 min
Place patient on OR table, attach frame to table, adjust positioning, shave scalp and sterilize frame	15 min
Enter stereotactic coordinates to guide system on frame	5 min
Apply drapes, inject local anesthesia into scalp, make incision and cranial bone opening	15 min
Insert stereotactic probe or instrument into targeted lesion, take biopsies, send to pathologist for exam	45 min
Remove probe, close scalp wound and apply dressing, remove stereotactic frame and take patient off OR table	15 min
Total time =	185 min

This total estimated time is a very close match to that from the Harvard3 data and supports our concern that the survey responses of 90 minutes have seriously misallocated the time for this part of 61751. Therefore, we propose that a composite approach to reconstruction of the work and RVW of 61751 be used to help correct this inaccurate data. We suggest using the Harvard 3 pre-service time of 75 minutes, since that seems adequate to cover all of the services provided before the application of the frame, which marks the beginning of the intra-service period. It seems likely that the survey respondents may have lumped time for application of the frame plus some of the scanning time to the pre-service period, as the higher pre-service survey time of 128 minutes suggests.

We also suggest using the survey time of 125 minutes for the post-service period, since that meets face validity as well as our survey time of 123 minutes while the Harvard3 time of 185 minutes seems excessive for post-op time.

When all of these adjusted time factors are used to recalculate a total work value, the result is 1674 which translates to a MFS95 RVW of 16.66 which is our recommended value for 61751.

CPT Code: 61751

SURVEY DATA:

Specialty: Neurological Surgery

CPT 61751 | Stats	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global)			
		Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)		Dischg. Day Mgmt.	Office Visits after discharge				
			Time	Time		Time	Time	Time	No. x Time		SUM	No. x Time		SUM	Time	No. x Time	SUM	
min	1	10	10	10	20	5	0	0	0	0	0	0	0	0	10	0	0	15
25th%	2	30	15	20	60	10	15	0	0	0	1	10	10	15	2	15	30	30
median	3	60	15	53	90	15	15	1	10	40	2	15	20	20	3	15	52	52
75th%	3	98	15	60	120	20	25	1	15	20	2	15	38	30	4	20	60	60
max	6	150	35	150	240	45	120	4	30	80	4	30	90	60	14	35	210	210
Intra-time #	90																	
Sample #																		
% response	43%																	

RATIONALE for recommendation:

Work:

Changes in past 5 years:

Rank Order (Ordinal) Valuation:

Prev. RUC or Refinement Valuation:

Time:

Op. Logs:

Anesthesia databases:

AANS94 Survey Key Refs:

Mental Effort & Judgement:

Technical Skill & Physical Effort:

Stress:

Intensity/Complexity:

Ease of doing procedure improved in past 5 years.

Ordinal values appropriate as listed in table of reference service except for 61751 with AANS94 data.

1992 RVW=10.91; incr. to 15.55 in 1993 by Refinement panel

More time due to use of CT scanning during procedure.

61 cases; avg. intra-service time=69 min.

88 cases; avg. anesth. time= 114 min.

Survey data indicate shorter time and less work than Harvard3.

More mental effort and judgment than 61790

Greater skill than 61790

Risk factors higher

Complexity somewhat greater, working at depth in the brain.

Public Comments

30-Jun-95

Code: 61751

1995 RVUs: 15.18

Recommended RVUs: 18.20

Ratio:

Long Descriptor: Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computerized axial tomography

Reference Set (y/n): N Global Period: 090 Frequency: 1,991 Impact: 6013

Source: 5 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61751	42.3	1.9	7.7	53.8	19.2	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61751	1978	2198	5.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61751	95.5	94.9	-0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61751	group practices	3.3
	neurological surgery	90.8
	neurology	2.1
	radiology	2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61751	191	13.5	MALIGNANT NEOPLASM OF BRAIN
	198	2.9	SECONDARY MALIGNANT NEOPLASM O

Public Comments

30-Jun-95

225	2.4	BENIGN NEOPLASM OF BRAIN AND OTH
239	3.8	NEOPLASMS OF UNSPECIFIED NATURE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61751							
AANS		090	090	18.66	15.18	0.81	10.35

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61751								
AANS	15.18	15.18	0.55	1.47	1.00	1.00	18.20	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notatw	Pret	Svdpre	ltime	Notett	Imppt
61751								
AANS	090	18.66		39	*	187		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61751									
AANS	*	1.0		10	10.5	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
61751									
AANS	*	15		18.20	15.18	*ns	3		0.060

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61760 Global Period: 090 Current RVW: 24.83 Recommended RVW: 21.00

CPT Descriptor: **Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended a decrease in RVW from 24.83 to 21.00.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Work/mib Hrvd3 AANS
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	75	186		186	1882		18.73	15.85		6.13
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	105	120	13	120		1600			15.92 AANS95	7.61 AANS95
61751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W/ COMPUTERIZED AXIAL TOMO	75	185	10	125		1674			18.68 *****	5.95 AANS94
61750	STEREOTACTIC BIOPSY, ASP OR EXCIS OF INTRACRANIAL LESION	70	133		169	1675		16.67	10.03	16.67	7.52
61735	CREATION SUBCORTICAL LESION/STEREOTACTIC METHOD	75	184		186	1881		18.72	17.08	18.72	6.20
61770	STEREOTACTIC LOCALIZATION W/ INSERTION OF CATHETERS/BRACHYTHERAPY	71	140		183	1987		19.78	15.14	19.78	8.96
61760	STEREOTACTIC IMPLANTATION DEPTH ELECTODES INTO CEREBREUM/ SEIZURE MONITORING								24.83	21.00	

RELATIONSHIP OF 61760 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:
61770 (STEREOTACTIC LOCALIZATION W/ INSERTION OF CATHETERS/BRACHYTHERAPY) is the reference service for this procedure. This service is used to treat lesions in patients with tumors in deep seated cerebral structures using multiple catheters implanted into the tumor bed for delivery of local radiation therapy. It involves more time, skill and risk than 61735, and the Harvard3 work value appears appropriate in relation to the other procedures listed. 61760 has no previous Harvard3 or current survey data to use for comparison. The basis for ranking this service is a comparison of the work involved in placing a series of depth electrodes into the brain in an area of demonstrated epileptogenic activity for monitoring. The elements of work compare rather well to the reference service, 61770, since both require stereotactic targeting and insertion of multiple catheters or probes connected to various devices outside the scalp for varying periods of time. The intensity elements of mental effort, technical skill, and stress are all comparable. It is probable that slightly more time is required for 61760 and therefore, we recommend a rank order placement slightly above that of 61770 for RVW. The present RVW of 24.83 seems to be out of scale with the other procedures listed and the value seems high. Therefore, we recommend a RVW of 21.00 to accomodate the extra time in 61760 while reducing the current high value.

The values for the remainder of the comparable procedures in this family are tabulated above for comparison, and they are arranged in ascending rank order for work, using the Harvard3 database for anchor points. We recommend the RVWs listed in the right column for this set of procedures.

RATIONALE for recommendation:

Work: Rank Order (Ordinal) Valuation: Ordinal values appropriate as listed in table of reference service

Time: Mental Effort & Judgement: Compares to 61770.

Technical Skill & Physical Effort: Comparable to 61770.

Stress: Risk factors high due to multiple punctures of brain.

Intensity/Complexity: Complexity somewhat greater, working at depth in the brain.

Public Comments

30-Jun-95

Code: 61760

1995 RVUs: 24.83

Recommended RVUs: 15.80

Ratio:

Long Descriptor: Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring

Reference Set (y/n): N Global Period: 090 Frequency: 66 Impact: -596

Source: 5 Year: 94 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey:

Societies Wishing to Comment: AANS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61760	0	0	0	100	100	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61760		68	

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61760		94.1	

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61760	anesthesiology	2.9
	group practices	23.5
	neurological surgery	70.6
	neurology	2.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61760	345	25	EPILEPSY

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61760							
AANS			090		24.83		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61760								
AANS	21.71	24.83			1.14	1.00	15.80	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61760								
AANS	090							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61760									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61760									
AANS				15.80	24.83				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61770 Global Period: 090 Current RVW: 15.14 Recommended RVW: 19.78

CPT Descriptor: Stereotactic localization, any method, including burr hole(s), with insertion of catheter(s) for brachytherapy

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended an increase in RVW from 15.14 to 19.78.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Work/min Hrvd3 AANS
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	
61790	STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION	69	82		79	1010		10.05	10.31		7.85
61791	STEREOTACTIC LESION, PERCUTANEOUS OF TRIGEMINAL MEDULLARY TRACT	68	119		85	1406		13.99	7.29	13.99	8.60
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	75	186		186	1882		18.73	15.85		6.13
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	105	120	13	120		1600			15.92 AANS86	7.61 AANS95
61751	STEREOTACTIC BIOPSY, ASP OR EXCIS, OF LESION W COMPUTERIZED AXIAL TOMO	75	185	10	125		1674			15.66 AANS84	5.95 AANS84
61750	STEREOTACTIC BIOPSY, ASP OR EXCIS OF INTRACRANIAL LESION	70	133		169	1675		16.67	10.03	16.67	7.52
61735	CREATION SUBCORTICAL LESION/STEREOTACTIC METHOD	75	184		186	1881		18.72	17.08	18.72	6.20
61770	STEREOTACTIC LOCALIZATION W INSERTION OF CATHETERS/BRACHYTHERAPY	71	140		183	1987		19.78	15.14	19.78	8.96

RELATIONSHIP OF 61770 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) is the reference service for this group of procedures. They have in common the use of stereotactic localization techniques to target a deep intracranial structure for purposes of biopsy, incision, stimulation, or destruction by either radiation or radiofrequency or injection. The reference procedure 61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) has a total work value of 1010 and a time of 82 minutes with a RVW of 10.31. This represents a close translation of the Harvard3 time and work data to the present MFS value for work. The comparable values for the remainder of the procedures in this family are tabulated above for comparison, and the procedures are arranged in ascending rank order for work, using the Harvard3 database for anchor points. We recommend the RVWs listed in the right column for this set of procedures.

In the case of 61770 (STEREOTACTIC LOCALIZATION WITH INSERTION OF CATHETERS FOR BRACHYTHERAPY), this service is used to treat lesions in patients with tumors in deep seated cerebral structures using multiple catheters implanted into the tumor bed for delivery of local radiation therapy. It involves more time, skill and risk than 61790, and the Harvard3 work value appears appropriate in relation to the other procedures listed. We recommend a RVW of 19.78.

CPT Code: 61770

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Ordinal values appropriate as listed in table of reference service

Prev. RUC or Refinement Valuation:

Time:

Op. Logs:

Harvard3 Database:

Undervalued time/Phase I or II & MFS92:

Mental Effort & Judgement:

More mental effort and judgment than 61790

Technical Skill & Physical Effort:

Greater skill than 61790

Stress:

Risk factors higher due to radiation hazards and multiple punctures of brain and tumor with catheters to carry the radioactive pellets.

Intensity/Complexity:

Complexity somewhat greater, working at depth in the brain.

Public Comments30-Jun-95

Code: 61770**1995 RVUs:** 15.14**Recommended RVUs:** 19.78**Ratio:****Long Descriptor:** Stereotactic localization, any method, including burr hole(s), with insertion of catheter(s) for brachytherapy**Reference Set (y/n):** N**Global Period:** 090**Frequency:** 82**Impact:** 380**Source:** 4**Year:** 93**Public Comment Letter:** 340**Reference Services:****CMD Comment:**

Societies Wishing to Survey: AANS**Societies Wishing to Comment:****Trends Analysis -- Beneficiary Information:**

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61770	100	0	0	0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61770	91	78	-7.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61770	94.5	89.7	-2.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61770	group practices	7.7
	neurological surgery	84.6
	neurology	7.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61770	239	25	NEOPLASMS OF UNSPECIFIED NATURE

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61770							
AANS		090	090	20.18	15.14	0.75	15.14

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61770								
AANS	15.14	15.14	0.75	1.00	1.00	1.00	19.78	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61770								
AANS	090	20.18		36	*	140		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61770									
AANS	*	1.0	*	10	10.5	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61770									
AANS	*	15		19.78	15.14	ns	3		0.091

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
CMD Comments
Comments on Misvalued Code**

CPT Code: 61791 Global Period: 090 Current RVW: 7.29 Recommended RVW: 13.99

CPT Descriptor: **Creation by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract**

Source and Summary of Comment to HCFA on this service: Public Comments by AANS. CMD Comments. CMD recommended increase in RVW from 7.29 to 13.29. AANS recommended a RVW of 13.99.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec. New RVW	Work/mla Hrvd3 AANS
61790	STEREOTACTIC LESION, PERCUTAN/GASSERIAN GANGLION	69	82		79	1010		10.05	10.31		7.85
61791	STEREOTACTIC LESION, PERCUTAN/TRIGEMINAL MEDULLARY TRACT	68	119		85	1406		13.99	7.29	13.99	8.60
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	75	186		186	1882		18.73	15.85		6.13
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	105	120	13	120		1600			15.92 AANS95	7.61 AANS86
81751	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF LESION W/ COMPUTERIZED AXIAL TOMO	75	185	10	125		1674			16.86 *****	5.96 AANS94
61750	STEREOTACTIC BIOPSY, ASP. OR EXCIS. OF INTRACRANIAL LESION	70	133		169	1675		16.67	10.03	16.67	7.52
61735	CREATION SUBCORTICAL LESION/STEREOTACTIC METHOD	75	184		186	1881		18.72	17.08	18.72	6.20
61770	STEREOTACTIC LOCALIZATION W/ INSERTION OF CATHETERS/BRACHYTHERAPY	71	140		183	1987		19.78	15.14	19.78	8.96

RELATIONSHIP OF 61791 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) is the reference service for this group of procedures. They have in common the use of stereotactic localization techniques to target a deep intracranial structure for purposes of biopsy, incision, stimulation, or destruction by either radiation or radiofrequency or injection. The reference procedure 61790 (STEREOTACTIC LESION, PERCUTANEOUS OF GASSERIAN GANGLION) has a total work value of 1010 and a time of 82 minutes with a RVW of 10.31. This represents a close translation of the Harvard3 time and work data to the present MFS value for work. The comparable values for the remainder of the procedures in this family are tabulated above for comparison, and the procedures are arranged in ascending rank order for work, using the Harvard3 database for anchor points. We recommend the RVWs listed in the right column for this set of procedures.

In the case of 61791 (STEREOTACTIC LESION PERCUTANEOUS OF TRIGEMINAL MEDULLARY TRACT), this service is used to in patients patients with neuralgic pain in the face. It involves more time, skill and risk than 61790, and the Harvard3 work value appears appropriate in relation to the other procedures listed. The Carrier Medical Directors recommended an increase from the present RVW of 7.29 to a new RVW of 13.29. This was an appropriate recommendation and our extrapolated RVW based on the Harvard3 time and work data supports our recommendation of 13.99.

CPT Code: 61791

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Ordinal values appropriate as listed in table of reference service

Prev. RUC or Refinement Valuation:

Time:

AANS94 Survey Key Refs:

Harvard3 Database:

Undervalued time/Phase I or II & MFS92:

Mental Effort & Judgement:

More mental effort and judgment than 61790

Technical Skill & Physical Effort:

Greater skill than 61790

Stress:

Risk factors higher

Intensity/Complexity:

Complexity greater, working at depth in the brain stem.

CMD Comments

30-Jun-95

Code: 61791

1995 RVUs: 7.29

Recommended RVUs: 13.29

Ratio: 0.82

Long Descriptor: Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract

Reference Set (y/n): N Global Period: 090 Frequency: 137 Impact: 822

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
61791			
	61790 TREAT TRIGEMINAL NERVE	10.31	090

CMD Comment:

Substantially more difficult than 61790.

Societies Wishing to Survey: AANS

Societies Wishing to Comment: AANS, AAPM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61791	100	0	0	100	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61791	223	154	-16.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61791	51.1	53.2	1.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61791		
	anesthesiology	2.6
	group practices	9.1
	neurological surgery	88.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61791			
	350	25	TRIGEMINAL NERVE DISORDERS

CMD Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61791							
AANS		090	090	14.28	7.29	0.51	7.29
CMD		090	090	14.28	7.29	0.51	7.29

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61791								
AANS	7.29	7.29	0.51	1.00	1.00	1.00	13.99	340
CMD	7.29	7.29	0.51	1.00	1.00	1.00	13.29	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61791								
AANS	090	14.28		35	*	119		50
CMD	090	14.28		35	*	119		50

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61791									
AANS	*	1.0	*	10	2.5	*	10	0.0	2.0
CMD	*	1.0	*	10	2.5	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61791									
AANS	*	15	j	13.99	7.29	ns	3		0.087
CMD	*	15	j	13.29	7.29	ns	3		0.087

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 61793 Global Period: 090 Current RVW: 16.70 Recommended RVW: 17.88

CPT Descriptor: **Stereotactic focused proton beam or gamma radiosurgery**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS**
AANS recommended increase in RVW from 16.70 to 17.88.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year old male with a history of renal cell carcinoma, now present in the right cerebellum. He has headaches, dizziness and compression of the fourth ventricle as seen on MRI scan. No other lesions are evident, and the chest exam is normal. The lesion enhances and is 2cm in diameter. Stereotactic radiosurgery is delivered using the gamma knife system.

Description of Pre-Service Work: includes review of previous medical records, evaluation of the imaging studies, and appropriate lab and screening studies. Pre-service work includes informed consent with the patient and family.

Description of Intra-Service Work: The intra-service work begins with the application of the stereotactic head frame under local anesthesia. The patient is then transported to Radiology where stereotactic imaging studies are obtained. This may be either MRI or angiography. The neurosurgeon must position and secure the patient on the imaging table and attach an appropriate stereotactic localizer. He then works with a radiologist or technician to identify the precise areas to be imaged by adjustment of the scanning geometry and by timing of the contrast injection(s). Finally, the neurosurgeon verifies that the target is optimally imaged. Dosimetry planning follows in conjunction with radiation oncology and a radiation physicist as well a computer programmer. The programmer processes all of the stereotactic images into the dose planning computer during this phase. This dose planning involves use of a computer based planning module to achieve an optimal dosimetry plan for the patient. A test is then done using the radiosurgical device to assure correct targeting and dosimetry. The patient is then placed in the device while still in the frame. Positioning is more complex due to the use of a stereotactic frame that requires coordinate indexing to the patient table. The treatment is then delivered. For each isocenter treated, the neurosurgeon must set the stereotactic coordinates, verified by other team members. Removal of the frame is done at the end of the service period.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of complications. The recovery room visit and discharge day management are included. Discharge records are prepared and post-discharge office visits are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec.New RVW	Work/mia Hrwd3 AANS
61790	STEREOTACTIC LESION, PERCUTAN /GASSERIAN GANGLION	69	82		79	1010		10.05	10.31		7.85
61791	STEREOTACTIC LESION, PERCUTAN /TRIGEMINAL MEDULLARY TRACT	68	119		85	1406		13.99	7.29	13.99	8.60
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	75	186		186	1882		18.73	15.85		6.13
61720	CREATION STEREOTACTIC LESION, GLOBUS PALLIDUS OR THALAMUS	105	120	13	120		1600			15.92 AANS95	7.61 AANS95
61751	STEREOTACTIC BIOPSY, ASP OR EXCIS. OF LESION W COMPUTERIZED AXIAL TOMO	75	185	10	125		1674		15.18		5.95 AANS94
61750	STEREOTACTIC BIOPSY, ASP OR EXCIS OF INTRACRANIAL LESION	70	133		169	1675		16.67	10.03	16.67	7.52
61735	CREATION SUBCORTICAL LESION/STEREOTACTIC METHOD	75	184		186	1881		18.72	17.08	18.72	6.20
61793	STEREOTACTIC FOCUSED PROTON BEAM OR GAMMA RADIOSURGERY	76	208		190	1917		19.08	16.70		5.55
61793	STEREOTACTIC FOCUSED PROTON BEAM OR GAMMA RADIOSURGERY	85	120		80		1222			12.16 AANS95	5.63 AANS95
61793	STEREOTACTIC FOCUSED PROTON BEAM OR GAMMA RADIOSURGERY	76	210		80		1797			17.88 AANS	5.63 AANS95
61770	STEREOTACTIC LOCALIZATION W INSERTION OF CATHETERS/BRACHTHERAPY	71	140		183	1987		19.78	15.14	19.78	8.96

CPT Code: 61793

SURVEY DATA:

Specialty: **Neurological Surgery**

61720	Stats	RVW	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)							
				Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Room Exit	Recovery	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Disch Day Mgmt.	Office Visits after discharge						
	min	12.00	0	40	0	0	30	0	0	0	0	0	0	1	10	10	10	1	15	15	
	25th%	16.63	0	55	0	15	68	8	0	0	0	0	0	1	10	10	11	1	15	19	
	median	20.00	1	60	10	15	120	18	0	0	0	0	0	1	13	13	15	2	18	35	
	75th%	25.00	1	60	15	30	195	20	10	0	0	0	0	1	15	15	15	2	20	40	
	max	31.04	1	90	15	150	240	30	20	0	0	0	0	1	15	15	20	2	30	60	
survey n		275																			
RVW resp		7																			
rate %		3%																			

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:
Prev. RUC or Refinement Valuation:

Ordinal values appropriate as listed in table of reference service
1992 RVW of 17.60 was retained.

Time:

Harvard3 Database:
Undervalued time/Phase I or II & MFS92:

Time values appear realistic for intra-service time..

Mental Effort & Judgement:
Technical Skill & Physical Effort:

More mental effort and judgment than 61790
Greater skill than 61790

Stress:

Risk factors higher

Intensity/Complexity:

Complexity greater due to need for precise targeting and dosimetry, frequently deep in brain or posterior fossa and adjacent to vital structures.

Public Comments

30-Jun-95

Code: 61793

1995 RVUs: 16.7

Recommended RVUs: 19.08

Ratio:

Long Descriptor: Stereotactic focused proton beam or gamma radiosurgery

Reference Set (y/n): N Global Period: 090 Frequency: 1,252 Impact: 2980

Source: 4 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment: ACR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61793	52.8	7.5	11.8	49.1	7.5	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61793	1042	1420	16.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61793	73.1	58	-7.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61793	group practices	12.2
	hematology/oncology	13.3
	neurological surgery	66.7
	radiology	6.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61793	191	10.2	MALIGNANT NEOPLASM OF BRAIN
	194	1.9	MALIGNANT NEOPLASM OF OTHER END
	198	5.6	SECONDARY MALIGNANT NEOPLASM O

Public Comments

30-Jun-95

225	1.9	BENIGN NEOPLASM OF BRAIN AND OTH
239	1.9	NEOPLASMS OF UNSPECIFIED NATURE
V10	1.9	PERSONAL HISTORY OF MALIGNANT NE

Harvard Data:

Comm	Modif	Packhrv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61793							
AANS		090	090	19.47	16.70	0.86	16.70

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61793								
AANS	16.70	16.70	0.86	1.00	1.00	1.00	19.08	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notatw	Pret	Svdpre	itime	Notatt	Imppt
61793								
AANS	090	19.47		40	*	208		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61793									
AANS	*	1.0	*	10	11.0	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61793									
AANS	*	15		19.08	16.70	ns	3		0.056

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61850 Global Period: 090 Current RVW: 15.98 Recommended RVW: 11.50

CPT Descriptor: **Twist drill or burr hole(s) for implantation of neurostimulator electrodes; cortical**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended reduction in RVW from 15.98 to 11.50.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVW's			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	Hrvd3 Intra-Wrk/mln
61108	TWIST DRILL BURR HOLES FOR DRAINAGE SUBDURAL HEM	55	44		131	956		9.52	10.80	9.00	10.02
61250	BURR HOLE(S) OR TREPHINE SUPRATENTORIAL EXPLORATORY UNILAT	56	52		113	944		9.40	11.03	9.40	9.38
61151	BURR HOLE(S) FOR SERIAL ASPIRATION OF ABSCESS OR CYST	57	57		119	1158		11.53	11.40		11.84
61850	TWIST DRILL OR BURR HOLE/IMPLANT CORTICAL ELECTRODES	58	73		106	932		9.28	15.98	11.50	6.74
61855	TWIST DRILL OR BURR HOLE/IMPLANT SUBCORTICAL ELECTRODES	58	75		107	942		9.38	12.94	12.50	6.65
61154	BURR HOLE(S)/EVACUATION OF HEMATOMA, EXTRA- OR SUBDURAL, UNILAT.	65	69		176	1212		12.06	13.67		7.61
61140	BURR HOLE OR TREPHINE/BIOPSY BRAIN OR INTRACRANIAL LESION	73	83		121	1278		12.72	14.84		9.17
61860	CRANIOTOMY/IMPLANT CORTICAL ELECTRODES	64	100		137	1302		12.96	11.20	19.60	7.47

RELATIONSHIP OF 61850 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference procedure is 61108 (TWIST DRILL, BURR HOLES FOR DRAINAGE OF SUBDURAL HEMATOMA) with a total work value of 956 and intra-service time of 44 minutes. 61850 has a total work of 932 and time of 73 minutes, while 61855 total work is 942 and time is 75 minutes. Based on rank order valuation, we recommend a RVW of 11.50 for 61850.

Comparison to 61860 (CRANIOTOMY FOR IMPLANTATION OF CORTICAL ELECTRODES) also shows that there is substantially more total work involved in the craniotomy compared to the twist drill or burr hole approach. The Harvard3 data strongly support a reduced RVW for 61850 with a total work value of 932 compared to the total work for 61860 of 1302. We recommend a RVW of 11.50 for 61850.

RATIONALE for recommendation:

Work:

Changes in past 5 years

Rank Order (Ordinal) Valuation:

The rank order listed in the reference table is appropriate.

Time:

Harvard3 Database:

Harvard3 database appears to reflect appropriate relativity within this family.

Mental Effort & Judgement:

Technical Skill & Physical Effort:

Stress:

Intensity/Complexity:

Public Comments

30-Jun-95

Code: 61850

1995 RVUs: 15.98

Recommended RVUs: 9.50

Ratio:

Long Descriptor: Twist drill or burr hole(s) for implantation of neurostimulator electrodes; cortical

Reference Set (y/n): N

Global Period: 090

Frequency: 3

Impact: -19

Source: 1

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment: AAPM

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61850	6	6	0

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61850	100	100	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61850	neurological surgery	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packdv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61850							
AANS		090	090	9.45	15.98	1.69	15.98

Harvard Data:

Public Comments

30-Jun-95

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61850								
AANS	15.98	15.98	1.69	1.00	1.00	1.00	9.50	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itme	Notett	Imppt
61850								
AANS	090	9.45		27	*	73		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
61850									
AANS	*	1.0	*	10	5.0	*	10	0.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61850									
AANS	*	15	J	9.50	15.98	ns	3		0.068

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61855 Global Period: 090 Current RVW: 12.94 Recommended RVW: 12.50

CPT Descriptor: **Twist drill or burr hole(s) for implantation of neurostimulator electrodes: subcortical**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended a reduction in RVW from 12.94 to 12.50.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Hrwd3 Intra- Wrk/min
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec.New RVW	
61108	TWIST DRILL, BURR HOLES FOR DRAINAGE SUBDURAL HEM	55	44		131	956		9.52	10.80	9.00	10.02
61250	BURR HOLE(S) OR TREPHINE SUPRATENTORIAL EXPLORATORY UNILAT	56	52		113	944		9.40	11.03	9.40	9.38
61151	BURR HOLE(S) FOR SERIAL ASPIRATION OF ABSCESS OR CYST	57	57		119	1158		11.53	11.40		11.84
61850	TWIST DRILL OR BURR HOLE/IMPLANT CORTICAL ELECTRODES	58	73		106	932		9.28	15.98	11.50	6.74
61855	TWIST DRILL OR BURR HOLE/IMPLANT SUBCORTICAL ELECTRODES	58	75		107	942		9.38	12.94	12.50	6.65
61154	BURR HOLE(S)/EVACUATION OF HEMATOMA, EXTRA- OR SUBDURAL, UNILAT	65	69		176	1212		12.06	13.67		7.61
61140	BURR HOLE OR TREPHINE/BIOPSY BRAIN OR INTRACRANIAL LESION	73	83		121	1278		12.72	14.84		9.17
61860	CRANIOTOMY/IMPLANT CORTICAL ELECTRODES	64	100		137	1302		12.96	11.20	19.60	7.47

RELATIONSHIP OF 61855 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference procedure is 61108 (TWIST DRILL, BURR HOLES FOR DRAINAGE OF SUBDURAL HEMATOMA) with a total work value of 956 and an intra-service time of 44 minutes. 61850 has a total work of 932 and time of 73 minutes, while 61855 total work is 942 and time is 75 minutes. Based on rank order valuation, we recommend a RVW of 12.50 for 61855.

Comparison to 61860 (CRANIOTOMY FOR IMPLANTATION OF CORTICAL ELECTRODES) also shows that there is substantially more work involved in the craniotomy compared to the twist drill or burr hole approach. The Harvard3 data strongly support a reduced RVW for 61855 and we recommend a comparable RVW of 12.50 for 61855.

RATIONALE for recommendation:

Work:

Changes in past 5 years

Rank Order (Ordinal) Valuation:

The rank order a listed in the reference table is appropriate.

Initial crosswalk or extrapolation misvaluation:

Prev. RUC or Refinement Valuation:

Time:

Harvard3 Database:

Undervalued time/Phase I or II & MFS92:

Harvard3 database appears to reflect correct relativity of this family.

Mental Effort & Judgement:

Technical Skill & Physical Effort:

Stress:

Intensity/Complexity:

Public Comments

30-Jun-95

Code: 61855 1995 RVUs: 12.94 Recommended RVUs: 10.00 Ratio:

Long Descriptor: Twist drill or burr hole(s) for implantation of neurostimulator electrodes; subcortical

Reference Set (y/n): N Global Period: 090 Frequency: 8 Impact: -24

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS

Societies Wishing to Comment: AAPM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
61855	0	0	0	0	0	0	100	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61855	7	10	19.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61855	100	80	-10

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61855	neurological surgery	80
	ophthalmology	20

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
61855	053	25	HERPES ZOSTER

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61855								

Public Comments

30-Jun-95

AANS	090	090	9.56	12.94	1.35	12.94
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Harvard Data:

Comm	Mfwk93	Mfwk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61855								
AANS	12.94	12.94	1.35	1.00	1.00	1.00	10.00	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61855								
AANS	090	9.56		27	*	75		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61855									
AANS	*	1.0	*	10	5.0	*	10	0.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfwk95	Sp	Phase	Twput	Iwput
61855									
AANS	*	15	j	10.00	12.94	ns	3		0.068

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61860 Global Period: 090 Current RVW: 11.20 Recommended RVW: 19.60

CPT Descriptor: **Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral; cortical**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 11.20 to 19.60.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	Hrvd3 Intra-Wrk/min
61108	TWIST DRILL, BURR HOLES FOR DRAINAGE SUBDURAL HEM	55	44		131	956		9.52	10.80	9.00	10.02
61250	BURR HOLE(S) OR TREPHINE SUPRATENTORIAL EXPLORATORY UNILAT	56	52		113	944		9.40	11.03	9.40	9.38
61151	BURR HOLE(S) FOR SERIAL ASPIRATION OF ABSCESS OR CYST	57	57		119	1158		11.53	11.40		11.84
61850	TWIST DRILL OR BURR HOLE/IMPLANT CORTICAL ELECTRODES	58	73		106	932		9.28	15.98	11.50	6.74
61855	TWIST DRILL OR BURR HOLE/IMPLANT SUBCORTICAL ELECTRODES	58	75		107	942		9.38	12.94	12.50	6.65
61154	BURR HOLE(S)/EVACUATION OF HEMATOMA, EXTRA- OR SUBDURAL, UNILAT.	65	69		176	1212		12.06	13.67		7.61
61140	BURR HOLE OR TREPHINE/BIOPSY BRAIN OR INTRACRANIAL LESION	73	83		121	1278		12.72	14.84		9.17
61860	CRANIOTOMY/IMPLANT.CORTICAL ELECTRODES	64	100		137	1302		12.96	11.20	19.60	7.47
61312	CRANIOTOMY/EVAC HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL	75	150		253	2040		20.30	20.54		
61312	CRANIOTOMY/EVAC HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL	80	120	100	325		2194			21.83 AANS94	

RELATIONSHIP OF 61860 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

These procedures all require a cranial opening for placement of intracranial stimulator electrodes. 61860 (CRANIOTOMY FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, CEREBRAL; CORTICAL) requires a small craniotomy for placement of electrodes over the cerebral cortex. The main reference procedure is 61154 (BURR HOLE FOR EVACUATION OF HEMATOMA, EXTRA- OR SUBDURAL, UNILATERAL) with a RVW of 13.67 and an intra-service time 69 minutes and a total work value of 1212. Note that 61154 was surveyed in AANS94 with time and work data that provided a total work value of 1361 which translates to a MFS95 RVW of 13.54, which is only 0.03 RVW less than the current RVW. This provides additional support for the higher total work value of this reference service and use as a reference service in this comparison.

The second procedure for comparison is 61850 (TWIST DRILL OR BURR HOLE/IMPLANT.CORTICAL ELECTRODES) which does the same service using only a twist drill or burr hole to implant the electrodes. The recommended RVW for 61850 is 11.50 RVW compared to the recommended RVW of 19.60 for this code, 61860.

A third reference is 61312 () which involves much of the same work elements as 61860. The fact that this service includes a craniotomy increases the work and complexity of the service into the range of other craniotomy procedures, and placement of the RVW for this service at 19.60 relates well to the references cited.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:
Prev. RUC or Refinement Valuation:

Rank order appropriate for face validation of listed procedures.
MFS92 gave 61154 a RVW of 12.84 which was increased to 14.00 by the May92 Refinement Panel.

Time:

AANS94 Survey Key Refs:

61154 was surveyed in AANS94 with results as noted above.

Mental Effort & Judgement:

Technical Skill & Physical Effort:

Craniotomy increases the amount of time and work relative to a twist drill or burr hole approach for the same purpose.

Public Comments30-Jun-95

Code: 61860	1995 RVUs: 11.2	Recommended RVUs: 12.96	Ratio:
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Long Descriptor: Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral; cortical

Reference Set (y/n): N Global Period: 090 Frequency: 3 Impact: 5

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment: AAPM

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61860	4	6	22.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61860	100	100	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61860	neurological surgery	66.7
	neurology	33.3

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61860							
AANS		090	090	13.21	11.20	0.85	11.20

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61860								
AANS	11.20	11.20	0.85	1.00	1.00	1.00	12.96	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
61860								
AANS	090	13.21		31	*	100		50

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuis	Offvis
61860									
AANS	*	1.0	*	10	7.5	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61860									
AANS	*	15	j	12.96	11.20	ns	3		0.076

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61865 Global Period: 090 Current RVW: 21.70 Recommended RVW: 21.70

CPT Descriptor: **Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral; subcortical**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommends retaining the present RVW of 21.70.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Hrwd3 Intra- Wrk/mln
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec.New RVW	
61108	TWIST DRILL, BURR HOLES FOR DRAINAGE SUBDURAL MEM	55	44		131	956		9.52	10.80	9.00	10.02
61250	BURR HOLE(S) OR TREPHINE SUPRATENTORIAL EXPLORATORY UNILAT	56	52		113	944		9.40	11.03	9.40	9.38
61151	BURR HOLE(S) FOR SERIAL ASPIRATION OF ABSCESS OR CYST	57	57		119	1158		11.53	11.40		11.84
61860	TWIST DRILL OR BURR HOLE/IMPLANT CORTICAL ELECTRODES	58	73		106	932		9.28	15.98	11.50	6.74
61855	TWIST DRILL OR BURR HOLE/IMPLANT SUBCORTICAL ELECTRODES	58	75		107	942		9.38	12.94	12.50	6.65
61154	BURR HOLE(S)/EVACUATION OF HEMATOMA, EXTRA- OR SUBDURAL, UNILAT	65	69		176	1212		12.06	13.67		7.61
61140	BURR HOLE OR TREPHINE/BIOPSY BRAIN OR INTRACRANIAL LESION	73	83		121	1278		12.72	14.84		9.17
61860	CRANIOTOMY/IMPLANT CORTICAL ELECTRODES	64	100		137	1302		12.96	11.20	19.60	7.47
61865	CRANIOTOMY/IMPLANT, SUBCORTICAL ELECTRODES	64	102		137	1321		13.15	21.70		7.47
61312	CRANIOTOMY/EVAC HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL	75	150		253	2040		20.30	20.54		
61312	CRANIOTOMY/EVAC HEMATOMA SUPRATENTORIAL EXTRA/SUBDURAL	80	120	100	325		2194			21.83 AANS94	

RELATIONSHIP OF 61865 TO KEY REFERENCE SERVICES and Other Rationales for RVW Recommendation:

These procedures all require a cranial opening for placement of intracranial stimulator electrodes. 61860 (CRANIOTOMY FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, CEREBRAL; CORTICAL) requires a small craniotomy for placement of electrodes over the cerebral cortex. The main reference procedure is 61154 (BURR HOLE FOR EVACUATION OF HEMATOMA, EXTRA- OR SUBDURAL, UNILATERAL) with a RVW of 13.67 and an intra-service time 69 minutes and a total work value of 1212. Note that 61154 was surveyed in AANS94 with time and work data that provided a total work value of 1361 which translates to a MFS95 RVW of 13.54, which is only 0.03 RVW less than the current RVW. This provides additional support for the higher total work value of this reference service and use as a reference service in this comparison.

The second procedure for comparison is 61850 (TWIST DRILL OR BURR HOLE/IMPLANT CORTICAL ELECTRODES) which does the same service using only a twist drill or burr hole to implant the electrodes. The recommended RVW for 61850 is 11.50 RVW compared to the recommended RVW of 21.70 for this code, 61865.

Comparison of the total work values and intra-service times in this group of procedures, based on time and work data from Harvard3, supports the relative value rank order as listed in the table.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Rank order appropriate for face validation of listed procedures.

Time:

Harvard3 Database:

See table above.

Mental Effort & Judgement:

Technical Skill & Physical Effort:

Craniotomy increases the amount of time and work relative to a twist drill or burr hole approach for the same purpose.

Stress:

Intensity/Complexity:

Placement of subcortical electrodes inherently of greater risk. Progressive increase in Harvard3 intensity per rank order.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61870 Global Period: 090 Current RVW: 5.77 Recommended RVW: 13.67

CPT Descriptor: **Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 5.77 to 13.67.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61253	BURR HOLES, INFRATENTORIAL, UNILAT OR BILATERAL	59	66		122	1132		11.27	13.00	11.27
61850	TWIST DRILL OR BURR HOLE/IMPLANT CORTICAL ELECTRODES	58	73		106	932		9.28	15.98	11.50
61855	TWIST DRILL OR BURR HOLE/IMPLANT SUBCORTICAL ELECTRODES	58	75		107	942		9.38	12.94	
61870	CRANIECTOMY/IMPLANT CEREBELLAR CORTICAL ELECTRODES	66	118		144	1373		13.67	5.77	13.67
61875	CRANIECTOMY/IMPLANT CEREBELLAR SUBCORTICAL ELECTRODES	67	120		144	1385		13.79	9.20	13.79
61860	CRANIECTOMY/IMPLANT CORTICAL ELECTRODES	64	100		137	1302		12.96	11.20	19.60
61314	CRANIOTOMY/EVAC. HEMATOMA INFRATENTORIAL, EXTRA/SUBDURAL	77	185		173	2293		22.82	22.78	
61305	CRANIECTOMY OR CRANIOTOMY, EXPLORAT INFRATENTORIAL (POST FOSSA)	80	197		196	2486		24.74	24.77	

RELATIONSHIP OF 61870 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61870 (CRANIECTOMY/IMPLANT CEREBELLAR CORTICAL ELECTRODES) involves exposure of the cerebellar surface by means of a craniectomy opening to implant neurostimulator electrodes over the cortical surface. Two reference service for comparison are 61314 (CRANIOTOMY/EVAC. HEMATOMA INFRATENTORIAL, EXTRA/SUBDURAL) and 61305 (CRANIECTOMY OR CRANIOTOMY, EXPLORAT. INFRATENTORIAL (POST. FOSSA)). Both of these services involve a similar approach with exposure of the cerebellum but with different purposes that entail substantially more intra-service and post-service time and work. The total work for these reference procedures are 2293 and 2486, with RVWs of 22.78 and 24.77 respectively. By contrast, the total work for 61870 is 1373 and the Harvard3 translated RVW is 13.67. The present MFS95 RVW is only 5.77 which is grossly undervalued for this type of procedure. This stems from an original MFS92 RVW of 6.02 which was incorporated into the MFS92 before the Harvard3 time and work refinement was completed in March 1992. At that time, the total work of 1373 was published, but despite reviews with the technical consulting groups, the increased value never was included as an update to subsequent editions of the MFS, even to the present.

We recommend an increase in the rank order anomaly for 61870 from 5.77 to 13.67.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Rank order appropriate as listed in table for total work and recommended RVWs.

Initial crosswalk or extrapolation misvaluation:

The initial low RVW was anomalous when compared to 61860 and 61865, even in the MFS92.

Time:

Harvard3 Database:

Harvard3 total work = 1373, which translates to a RVW of 13.67.

Undervalued time/Phase I or II & MFS92:

Initial MFS92 RVW was 6.08, from extrapolation or charge based conversion.

Mental Effort & Judgement:

The mental and judgment factors are greater than those for 61860 which applies this same service to the brain surface above the tentorium.

Technical Skill & Physical Effort:

The skill and effort of a posterior fossa exposure are more than for a standard craniotomy.

Intensity/Complexity:

Public Comments

30-Jun-95

Code: 61870

1995 RVUs: 5.77

Recommended RVUs: 13.67

Ratio:

Long Descriptor: Craniectomy for implantation of neurostimulator electrodes, cerebellar, cortical

Reference Set (y/n): N Global Period: 090 Frequency: 0 Impact: 0

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS

Societies Wishing to Comment: AAPM

Trends Analysis - Beneficiary Information:

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
61870	1	.	.

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61870	100	.	.

Trends Analysis - Specialty Mix:

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhvr	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61870							
AANS		090	090	13.94	5.77	0.41	5.77

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61870								
AANS	5.77	5.77	0.41	1.00	1.00	1.00	13.67	340

Harvard Data:

Cemm	Pack95	Hrvtotwk	Notatw	Pret	Svdpre	Itme	Notett	Imppt
61870								
AANS	090	13.94		33	*	118		50

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61870									
AANS	*	1.0	*	10	7.5	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61870									
AANS	*	15	J	13.67	5.77	ns	3		0.068

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61875 Global Period: 090 Current RVW: 9.20 Recommended RVW: 13.79

CPT Descriptor: **Craniectomy for implantation of neurostimulator electrodes, cerebellar; subcortical**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 9.20 to 13.79.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61855	TWIST DRILL OR BURR HOLE/IMPLANT SUBCORTICAL ELECTRODES	58	75		107	942		9.38	12.94	
61253	BURR HOLES, INFRATENTORIAL, UNILAT OR BILATERAL	59	66		122	1132		11.27	13.00	11.27
61154	BURR HOLE(S)/EVACUATION OF HEMATOMA EXTRA- OR SUBDURAL, UNILAT.	65	69		176	1212		12.06	13.67	
61870	CRANIECTOMY/IMPLANT CEREBELLAR CORTICAL ELECTRODES	66	116		144	1373		13.67	5.77	13.67
61875	CRANIECTOMY/IMPLANT CEREBELLAR SUBCORTICAL ELECTRODES	67	120		144	1385		13.79	9.20	13.79
61860	CRANIOTOMY/IMPLANT CORTICAL ELECTRODES	64	100		137	1302		12.96	11.20	19.60
61314	CRANIOTOMY/EVAC HEMATOMA INFRATENTORIAL, EXTRA/SUBDURAL	77	185		173	2293		22.82	22.78	
61305	CRANIECTOMY OR CRANIOTOMY EXPLORAT INFRATENTORIAL (POST FOSSA)	80	197		196	2486		24.74	24.77	

RELATIONSHIP OF 61875 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61875 (CRANIECTOMY/IMPLANT CEREBELLAR SUBCORTICAL ELECTRODES) involves exposure of the cerebellar surface by means of a craniectomy opening to implant neurostimulator electrodes into the subcortex. Two reference service for comparison are 61314 (CRANIOTOMY/EVAC HEMATOMA INFRATENTORIAL, EXTRA/SUBDURAL) and 61305 (CRANIECTOMY OR CRANIOTOMY, EXPLORAT, INFRATENTORIAL (POST, FOSSA)). Both of these services involve a similar approach with exposure of the cerebellum but with different purposes that entail substantially more intra-service and post-service time and work. The total work for these reference procedures are 2293 and 2486, with RVWs of 22.78 and 24.77 respectively. By contrast, the total work for 61875 is 1385 and the Harvard3 translated RVW is 13.79. The present MFS95 RVW is only 9.20 which is grossly undervalued for this type of procedure. This stems from an original MFS92 RVW of 9.69 which was incorporated into the MFS92 before the Harvard3 time and work refinement was completed in March 1992. At that time, the total work of 1385 was published, but despite reviews with the technical consulting groups, the increased value never was included as an update to subsequent editions of the MFS, even to the present.

We recommend an increase in this rank order anomaly for 61875 from 9.20 to 13.79.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation: Rank order appropriate as listed in table for total work and recommended RVWs.

Initial crosswalk or extrapolation misvaluation: The initial low RVW was anomalous when compared to 61860 and 61865, even in the MFS92.

Time:

Harvard3 Database: Harvard3 total work = 1385, which translates to a RVW of 13.67.
Undervalued time/Phase I or II & MFS92: Initial MFS92 RVW was 9.69, from extrapolation or charge based conversion.

Mental Effort & Judgement:

The mental and judgment factors are greater than those for 61860 which applies this same service to the brain surface above the tentorium.

Technical Skill & Physical Effort:

The skill and effort of a posterior fossa exposure are more than for a standard craniotomy.

Intensity/Complexity:

Public Comments30-Jun-95

Code: 61875**1995 RVUs:** 9.2**Recommended RVUs:** 13.79**Ratio:****Long Descriptor:** Craniectomy for implantation of neurostimulator electrodes, cerebellar, subcortical**Reference Set (y/n):** N **Global Period:** 090 **Frequency:** 0 **Impact:** 0**Source:** 2 **Year:** 92 **Public Comment Letter:** 340**Reference Services:****CMD Comment:**

Societies Wishing to Survey: AANS**Societies Wishing to Comment:** AAPM**Trends Analysis -- Beneficiary Information:**

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61875	1		

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61875	100		

Trends Analysis -- Specialty Mix:**Claims-Level Diagnosis Information:****Harvard Data:**

Comm	Modif	Packdv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61875							
AANS		090	090	14.06	9.20	0.65	9.20

Harvard Data:

Public Comments

30-Jun-95

Comm	Mawk93	Mfswk94	Rato2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61875								
AANS	9.20	9.20	0.65	1.00	1.00	1.00	13.79	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itme	Notett	Imppt
61875								
AANS	090	14.06						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
61875									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61875									
AANS			j	13.79	9.20	ns	3		

CPT Code: 62180

RELATIONSHIP OF 62180 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

62180 (VENTRICULOSTOMY (TORKILDSEN)) involves an occipital burr hole, introduction of a ventricular catheter, tunneling the catheter beneath the scalp into the suboccipital region, and then introducing the distal end of the catheter into the cisterna magna. The purpose is to provide a bypass for an aqueduct of Sylvius obstruction.

The reference procedures for 62180 VENTRICULOSTOMY (TORKILDSEN) are 61210 (BURR HOLES FOR IMPLANTING VENTRICULAR CATHETER) + 61253 (BURR HOLE(S), INFRATENTORIAL). The MFS95 RVW for the occipital burr hole and introduction of the ventricular end of the catheter (61210) is 4.72 revised to 5.84. Since 61210 has a Global of 000, the Post- time and work reduction would indicate about 2.0 units of reduction from the total RVW of 5.84 giving a contribution from 61210 of 3.0 RVW.

The RVW for 61253 and opening the posterior fossa is 13.00 revised to 11.27. The amount of work and time involved in opening the posterior fossa over the cisterna magne is greater than a simple burr hole and requires a midline incision down over the foramen magnum and C1. This requires considerably more time than the listed 71 minutes, and our recent survey median reports 161 intra-service minutes as well as longer pre- and post-service times. The total work from the survey is 1981 compared to a total of 1530 from the Harvard3 data. This warrants an an increase in the recommended RVW from the current 12.72 to 19.71 which is the translation of the survey total work to the MFS95 scale.

SURVEY DATA:

Specialty: Neurological Surgery

62180	Stats	RVW	LOS	PRE-SERVICE Time			INTR A TIME	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global)					
				Days	Time	Time		Time	Skin Open to Skin Close	Skin to O.R. Ext	Close to Reco very	ICU/CCU Visits	No.x	Time	SUM	No.x	Time	SUM	Disch Day Mgmt.	No.x	Time	SUM
	min	15.00	4	40	15	30	150	20	20	0	0	0	2	15	30	20	2	15	30			
	25th%	16.50	4	45	15	45	158	26	20	0	8	6	2	19	42	26	2	19	38			
	median	18.00	4	50	15	60	165	33	20	2	15	23	3	23	56	33	2	23	48			
	75th%	19.50	4	55	15	75	173	39	20	2	23	51	3	26	72	39	2	26	53			
	max	21.00	4	50	15	90	180	45	20	3	30	90	3	30	90	45	2	30	60			
survey n	275																					
RVW resp	2																					
rate %	0%																					

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation: Rank order valuation appropriate as listed in table above.
 Prev. RUC or Refinement Valuation: May 1992 Panel increased RVW to 13.03 from original 12.72

Time:

AANS95 Survey: See table above for time and work data from current survey.
 Harvard3 Database: Harvard3 time and work data appear to reflect appropriate relativity in this family of services.

Undervalued time/Phase I or II & MFS92: MFS92 RVW appears unchanged to date, reflecting undervaluation from inception of the MFS.

Mental Effort & Judgement:

Mental effort & judgment for 61280 greater than reference services.

Technical Skill & Physical Effort:

Skill and effort at proper placement of shunt catheter and avoidance of CSF leakage greater then reference service.

Stress:

Stress and risk only slightly greater.

Intensity/Complexity:

Complexity and intensity slightly higher. Note 2 ICU visits.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 62180 Global Period: 090 Current RVW: 12.72 Recommended RVW: 19.71

CPT Descriptor: **Ventriculocisternostomy (Torkildsen type operation)**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 12.72 to 19.71. **AANS95 survey.**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50 year old man has a workup for headaches and visual disturbance and an MRI scan reveals hydrocephalus with stenosis of the aqueduct. After a general workup, a bypass shunt procedure is done by placing a shunt catheter in the posterior portion of one lateral ventricle, tunnelling the distal end beneath the scalp, and introducing and anchoring the distal end in the cisterna magna, thereby bypassing the stenotic aqueduct.

Description of Pre-Service Work: includes review of imaging studies, review of past medical history and appropriate lab studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup. Additional pre-service work is entailed in positioning the patient since the approach requires either a prone or sitting position on the operating table, with attendant anchoring of the head in a fixation device.

Description of Intra-Service Work: A scalp incision and burr hole are placed over the occiput lateral to midline. A shunt catheter is introduced into the posterior portion of the lateral ventricle. The distal end of the catheter is tunneled beneath the scalp into the suboccipital region, which is opened low in the midline to expose the arch of C1 and the lower portion of the suboccipital bone. The rim of the foramen magnum is enlarged superiorly and the arch of C1 removed. The dura is opened in midline and retracted laterally. The shunt catheter tip is introduced into the subarachnoid space after incision of the arachnoid and anchored to the inner dura. The dura is then closed water-tight, and the muscle and fascia and scalp are closed in layers without drainage. The burr hole wound is also closed. Dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of leakage of ventricular fluid or infection. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61210	BURR HOLE/VENTRICULAR CATHETER, RESERVOIR OR PRESSURE DEVICE	45	44		76	587		5.84	4.72	5.84
61253	BURR HOLES, INFRATENTORIAL, UNILAT OR BILATERAL	59	66		122	1132		11.27	13.00	11.27
62223	CREATION OF SHUNT: VENTRICULO-PERITONEAL- PLEURAL OR OTHER TERMINUS	55	102		150	1224		12.18	12.81	13.84
62180	VENTRICULOCISTERNOSTOMY (TORKILDSEN)	71	161		127	1530		15.23	12.72	
62180	VENTRICULOCISTERNOSTOMY (TORKILDSEN)	125	165	23	186		1981			19.71 AANS95

Public Comments30-Jun-95

Code: 62180

1995 RVUs: 12.72

Recommended RVUs: 15.23

Ratio:

Long Descriptor: Ventriculocisternostomy (Torkildsen type operation)

Reference Set (y/n): N Global Period: 090 Frequency: 58 Impact: 146

Source: 5 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
62180	84	58	-16.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
62180	90.5	93.1	1.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
62180	neurological surgery	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packdrv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
62180							
AANS		090	090	15.53	12.72	0.82	12.08

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
62180								
AANS	12.72	12.72	0.78	1.05	1.00	1.00	15.23	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
62180								
AANS	090	15.53		37	*	161		53

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
62180									
AANS	*	1.0	*	10	6.0	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
62180									
AANS	*	15		15.23	12.72	ns	3		0.063

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 62194 Global Period: 010 Current RVW: 2.81 Recommended RVW: 4.50

CPT Descriptor: **Replacement or irrigation, subarachnoid/subdural catheter**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 2.81 to 4.50.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVW's		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
62194	REPLACEMENT OR IRRIGATION, SUBARACHNOID-SUBDURAL CATHETER	48	48		71	611		6.08	2.81	4.50
62194	REPLACEMENT OR IRRIGATION, SUBARACHNOID-SUBDURAL CATHETER	80	75		115		728			7.25
62225	REPLACEMENT OR IRRIGATION, VENTRICULAR CATHETER	47	41		83	668		6.65	4.71	
62256	SHUNT, REMOVAL COMPLETE SYSTEM WITHOUT REPLACEMENT	47	44		83	627		6.24	5.9	
62230	SHUNT, REPLACEMENT OR REVISION OF OBSTRUCTED VALVE OR CATHETER	57	72		96	817		8.13	9.71	
62190	CREATION OF SHUNT SUBARACH/SUBDURAL-ATRIAL, JUGULAR, AURICULAR	63	103		109	1053		10.48	10.13	

RELATIONSHIP OF 62194 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference service for this code is 62225 which represents the next step up in complexity and intensity, involving penetration of the brain rather than entry to the subdural/subarachnoid space with catheter replacement. The brain entry is clearly more intensive and the Harvard3 times for post-service slightly longer for 62225, but the total work values are 668 compared to 611, so the RVW for 62194 should be slightly lower than 62225 and we recommend a reduction to 4.50 units.

RATIONALE for recommendation:

Work:	Rank Order (Ordinal) Valuation:	Basis for readjusting Harvard3 calculated RVW downward to remain reasonable within same family of services.
Time:	Harvard3 Database:	Data used in estimation of final RVW
Mental Effort & Judgement:	Technical Skill & Physical Effort:	Less than 62225.
Stress:	Intensity/Complexity:	Less than 62225
		Less than 62225

Public Comments

30-Jun-95

Code: 62194

1995 RVUs: 2.81

Recommended RVUs: 4.50

Ratio:

Long Descriptor: Replacement or irrigation, subarachnoid/subdural catheter

Reference Set (y/n): N

Global Period: 010

Frequency: 153

Impact: 259

Source: 1

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
62194	33.3	0	0	33.3	33.3	0	0	33.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
62194	138	128	-3.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
62194	32.6	56.3	11.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
62194	anesthesiology	17.2
	general surgery	3.1
	internal medicine	3.1
	neurological surgery	45.3
	neurology	23.4
	orthopedic surgery	6.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
62194	355	8.3	MONONEURITIS OF LOWER LIMB AND U

Public Comments

30-Jun-95

401	8.3	ESSENTIAL HYPERTENSION
410	8.3	ACUTE MYOCARDIAL INFARCTION
724	8.3	OTHER AND UNSPECIFIED DISORDERS O
787	8.3	SYMPTOMS INVOLVING DIGESTIVE SYS
852	8.3	SUBARACHNOID, SUBDURAL, AND EXTR
996	8.3	COMPLICATIONS PECULIAR TO CERTAI
998	8.3	OTHER COMPLICATIONS OF PROCEDUR

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
62194							
AANS		010	010	6.21	2.81	0.45	2.81

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
62194								
AANS	2.81	2.81	0.45	1.00	1.00	1.00	4.50	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
62194								
AANS	010	6.21		23	*	48		35

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
62194									
AANS	*	1.0	*	10	3.0	*	10	0.0	1.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
62194									
AANS	*	10		4.50	2.81	ns	3		0.065

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 62200 Global Period: 090 Current RVW: 13.24 Recommended RVW: 17.33

CPT Descriptor: **Ventriculocisternostomy, third ventricle**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.
AANS recommended an increase in RVW from 13.24 to 17.33.** **AANS95 survey in progress.**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50 year old man has a workup for headaches and visual disturbance and an MRI scan reveals hydrocephalus with stenosis of the aqueduct. After a general workup, a spinal fluid diversion procedure is done by a small craniotomy, entry into one lateral ventricle and then the foramen of Monroe to the floor of the third ventricle. A small opening is created in the floor of the third ventricle to allow ventricular fluid to enter the basal cisterns thereby bypassing the stenotic aqueduct.

Description of Pre-Service Work: includes review of imaging studies, review of past medical history and appropriate lab studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup.

Description of Intra-Service Work: A frontal scalp flap is opened and a small craniotomy flap made. The dura is opened in and the underlying cortex is incised to develop a tract to enter the anterior lateral ventricle. After entering the ventricle, the foramen of Monroe is entered and a small opening is made in the floor of the third ventricle. After confirming patency of the opening and hemostasis, the retractors are removed from the cerebrotomy tract, the dura closed and the bone flap replaced and anchored. The scalp is closed in layers without drainage. Dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of leakage of ventricular fluid or infection. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec. New RVW
61156	BURR HOLES FOR ASPIRATION OF HEMATOMA OR CYST, INTRACEREBRAL	60	70		127	1286		12.80	15.23	
62180	VENTRICULOCISTERNOSTOMY (TORKILDSEN)	71	161		127	1530		15.23	12.72	15.23
62201	VENTRICULOSTOMY, THIRD VENTRICLE, STEREOTACTIC METHOD	68	123		163	1569		15.62	12.10	15.62
62201	VENTRICULOSTOMY, THIRD VENTRICLE, STEREOTACTIC METHOD	143	75	13	143		1360			13.54 AANS95
62200	THIRD VENTRICULOCISTERNOSTOMY	71	131		172	1851		18.42	13.24	18.42
62200	THIRD VENTRICULOCISTERNOSTOMY	80	120		153		1742			17.33 AANS95

RELATIONSHIP OF 62200 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The last two procedures in the table, 62201 (VENTRICULOSTOMY, THIRD VENTRICLE, STEREOTACTIC METHOD) and 62200 (THIRD VENTRICLE, VENTRICULOSTOMY) involve a cranial opening for entry into the third ventricle for the purpose of fenestrating the anterior floor into the region of the chiasmatic cistern, thereby bypassing an aqueductal or posterior third ventricle obstruction. The difference in the two codes is that 62201 uses stereotaxis for guidance and targeting while 62200 involves more surgical work in directly opening a tract into the anterior third ventricle, usually via a cerebrotomy into the anterior horn of the lateral ventricle. The reference procedures for 62200 (THIRD VENTRICULOCISTERNOSTOMY) are 61156 (BURR HOLE WITH ASPIRATION OF HEMATOMA OR CYST, INTRACEREBRAL) at RVW 15.23, and 62201 (VENTRICULOSTOMY, THIRD VENTRICLE, STEREOTACTIC METHOD) with a RVW of 15.23. The additional work of a cerebrotomy with entry into the lateral and third ventricle support an additional 2.1 RVWs to a total of 17.33 RVWs, which is the MFS95 conversion from the survey work total.

CPT Code: 62200

SURVEY DATA:

Specialty: Neurological Surgery

62200	Stats	RVW	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
			Hosp. Stay	Eval. before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day Mgmt.	Office Visits after discharge						
			Days	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM	
	min	20.00	4	40	10	20	90	20	20	1	15	15	2	15	30	15	2	15	3
	25th%	21.25	4	41	11	23	105	21	20	1	16	16	3	15	38	16	2	15	3
	median	22.50	5	43	13	25	120	23	20	1	18	18	3	15	46	18	2	15	3
	75th%	23.75	5	44	14	28	135	24	20	1	19	19	4	15	53	19	2	15	3
	max	25.00	5	45	15	30	150	25	20	1	20	20	4	15	60	20	2	15	3
csurvey n		275																	
RVW resp		2																	
rate %		0%																	

RATIONALE for recommendation:

Work:

Changes in past 5 years

Increasing interest in this procedure as treatment in some forms of hydrocephalus to avoid a shunt procedure.

Rank Order (Ordinal) Valuation:

The RVW recommended meets reasonable rank order placement for this family

Time:

AANS95 Survey:
Harvard3 Database:

Few responses in survey but data appear reasonable compared to refs. Harvard3 time and work data support rank order & RVWs as listed in table.

Mental Effort & Judgement:

Higher mental effort in this service compared to 61156.

Technical Skill & Physical Effort:

Technical skill higher in order to enter lateral and then anterior third ventricle, then make opening in proper place in floor adjoining hypothalamus.

Stress:

Substantial risk associated with operating inside the third ventricle and entering the cistern in front of the basilar artery.

Intensity/Complexity:

High intensity and complexity.

Public Comments

30-Jun-95

Code: 62200

1995 RVUs: 13.24

Recommended RVUs: 18.42

Ratio:

Long Descriptor: Ventriculocisternostomy, third ventricle;

Reference Set (y/n): N

Global Period: 090

Frequency: 91

Impact: 471

Source: 1

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey:

AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
62200	20	0	0	60	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
62200	89	106	9.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
62200	93.3	98.1	2.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
62200	neurological surgery	92.5
	neurology	3.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
62200	331	10	OTHER CEREBRAL DEGENERATIONS
	333	5	OTHER EXTRAPYRAMIDAL DISEASE AN
	430	10	SUBARACHNOID HEMORRHAGE
	431	5	INTRACEREBRAL HEMORRHAGE
	724	5	OTHER AND UNSPECIFIED DISORDERS O

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
62200							
AANS		090	090	18.80	13.24	0.70	13.24

Harvard Data:

Comm	Mawk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
62200								
AANS	13.24	13.24	0.70	1.00	1.00	1.00	18.42	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
62200								
AANS	090	18.80		36	*	131		57

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
62200									
AANS	*	1.0	*	10	10.0	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
62200									
AANS	*	15		18.42	13.24	ns	3		0.090

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61885 Global Period: 090 Current RVW: 2.35 Recommended RVW: 5.28

CPT Descriptor: **Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 2.35 to 5.28.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61888	REVISION OR REMOVAL INTRACRANIAL NEUROSTIMULATOR RECEIVER	45	34		53	469		4.67	3.10	4.67
61885	INCISION/PLACEMENT OF NEUROSTIMULATOR SUBQ RECEIVER	46	34		64	530		5.28	2.35	5.28
61880	REVISION OR REMOVAL INTRACRANIAL ELECTRODES	47	46		67	517		5.15	5.72	

RELATIONSHIP OF 61885 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:
61885 (INCISION/PLACEMENT OF NEUROSTIMULATOR SUBQ RECEIVER) requires surgical preparation of a subcutaneous pocket for implantation of a neurostimulator receiver and connection to implanted intracranial electrodes. The reference service for comparison is 61880 (REVISION OR REMOVAL INTRACRANIAL ELECTRODES) which describes the surgical management of the intracranial electrodes associated with the neurostimulator receiver. The RVW for this reference service has been stable since MFS92 with a reasonable Harvard3 total work value and RVW. The original RVW for 61885 was only 2.48 and the changes that appeared in Harvard3 in March 1992 were not included in updates to the subsequent editions of the MFS, even to 1995. Consequently, the RVW of 2.35 remains disproportionately low compared to 61880, and does not accurately reflect the greater amount of work that was reflected in the Harvard3 data. We recommend that this be corrected by increasing the RVW to 5.28 which will re-establish relativity within this group of codes.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:	Rank order appropriate as listed in table.
Initial crosswalk or extrapolation misvaluation:	The initial low RVW was anomalous when compared to 61880 in the MFS92.

Time:

Harvard3 Database:	Harvard3 total work = 530, which translates to a RVW of 5.28.
Undervalued time/Phase I or II & MFS92:	Initial MFS92 RVW was 2.48, from extrapolation or charge based conversion.

Mental Effort & Judgement:

Technical Skill & Physical Effort:

Stress:

Intensity/Complexity:

Public Comments

Code: 61885

1995 RVUs: 2.35

Recommended RVUs: 5.28

Ratio:

Long Descriptor: Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling

Reference Set (y/n): N Global Period: 090 Frequency: 11 Impact: 32

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment: AAPM

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
61885	22	14	-20.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61885	100	100	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
61885	neurological surgery	85.7
	neurology	14.3

Claims-Level Diagnosis Information:

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61885	AANS		090	090	5.38	2.35	0.44	2.35

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk34	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61885								
AANS	2.35	2.35	0.44	1.00	1.00	1.00	5.28	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
61885								
AANS	090	5.38		21	*	34		33

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
61885									
AANS	*	1.0	*	10	2.5	*	10	0.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61885									
AANS	*	15	j	5.28	2.35	ns	3		0.078

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 61888 Global Period: 010 Current RVW: 3.10 Recommended RVW: 4.67

CPT Descriptor: **Revision or removal of cranial neurostimulator pulse generator or receiver**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 3.10 to 4.67.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
61888	REVISION OR REMOVAL INTRACRANIAL NEUROSTIMULATOR RECEIVER	45	34		53	469		4.67	3.10	4.67
61885	INCISION/PLACEMENT OF NEUROSTIMULATOR SUBQ RECEIVER	46	34		64	530		5.28	2.35	5.28
61880	REVISION OR REMOVAL INTRACRANIAL ELECTRODES	47	46		67	517		5.15	5.72	

RELATIONSHIP OF 61888 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

61888 (REVISION OR REMOVAL INTRACRANIAL NEUROSTIMULATOR SUBQ RECEIVER) requires surgical exposure of the subcutaneous pocket that contains an implanted neurostimulator receiver. The reference service for comparison is 61880 (REVISION OR REMOVAL INTRACRANIAL ELECTRODES) which describes the surgical management of the intracranial electrodes associated with the neurostimulator receiver. The RVW for this reference service has been stable since MFS92 with a reasonable Harvard3 total work value and RVW. The original RVW for 61883 was only 3.26 and the changes that appeared in Harvard3 in March 1992 were not included in updates to the subsequent editions of the MFS, even to 1995. Consequently, the RVW of 3.10 remains disproportionately low compared to 61880, and does not accurately reflect the greater amount of work that was represented in the Harvard3 data. We recommend that this be corrected by increasing the RVW to 4.67 which will re-establish relativity within this group of codes.

RATIONALE for recommendation:

Work:
 Rank Order (Ordinal) Valuation: Rank order appropriate as listed in table.
 Initial crosswalk or extrapolation misvaluation: The initial low RVW was anomalous when compared to 61880 in the MFS92.

Time:
 Harvard3 Database: Harvard3 total work = 469, which translates to a RVW of 4.67.
 Undervalued time/Phase I or II & MFS92: Initial MFS92 RVW was 3.26, from extrapolation or charge based conversion.

Mental Effort & Judgement:
Technical Skill & Physical Effort:
Stress:
Intensity/Complexity:

Public Comments

30-Jun-95

Code: 61888

1995 RVUs: 3.1

Recommended RVUs: 4.67

Ratio:

Long Descriptor: Revision or removal of cranial neurostimulator pulse generator or receiver

Reference Set (y/n): N Global Period: 010 Frequency: 15 Impact: 24

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey:

Societies Wishing to Comment: AAPM

Trends Analysis - Beneficiary Information:

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
61888	18	16	-5.7

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
61888	88.9	62.5	-13.2

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
61888	general/family practice	12.5
	neurological surgery	87.5

Claims-Level Diagnosis Information:

Harvard Data:

	Comm	Modif	Packhrv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
61888	AANS		010	010	4.77	3.10	0.65	3.10

Public Comments30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
61888								
AANS	3.10	3.10	0.65	1.00	1.00	1.00	4.67	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notatt	Imppt
61888								
AANS	010	4.77		20	*	34		33

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
61888									
AANS	*	1.0	*	10	2.0	*	10	0.0	1.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
61888									
AANS	*	10		4.67	3.10	ns	3		0.071

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 62201 Global Period: 090 Current RVW: 12.10 Recommended RVW: 13.54

CPT Descriptor: **Ventriculocisternostomy, third ventricle; stereotactic method**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.
AANS recommended an increase in RVW from 12.10 to 13.54.**
AANS95 survey in progress.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50 year old man has a workup for headaches and visual disturbance. An MRI scan reveals hydrocephalus with stenosis of the aqueduct. After a general workup, a spinal fluid diversion procedure is done by stereotactic technique. The floor of the third ventricle is punctured by an instrument introduced via the stereotactic guidance system.

Description of Pre-Service Work: includes review of imaging studies, review of past medical history and appropriate lab studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup.

Description of Intra-Service Work: Initial work includes the application of the stereotactic frame, monitoring of scanning and the calculation of the target coordinates. The patient is returned to the operating room where a frontal burr hole is made. The dura is opened and the underlying cortex is incised to allow the stereotactic probe to pass into the lateral ventricle. The stereotactic coordinates are set into the frame and guidance system. An operating ventriculoscope is attached to the guide on the stereotactic. The ventriculoscope is then introduced through the cortical incision and passed into the lateral ventricle. After entering the ventricle, the foramen of Monroe is entered using visual guidance and a small opening is made in the floor of the third ventricle. After confirming patency of the opening and hemostasis, the ventriculoscope is removed from the operative tract, the dura closed and the scalp is closed in layers without drainage. The frame is removed and dressings are applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of leakage of ventricular fluid or infection. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
62201	VENTRICULOSTOMY, THIRD VENTRICLE, STEREOTACTIC METHOD	68	123		163	1569		15.62	12.10	
62201	VENTRICULOSTOMY, THIRD VENTRICLE, STEREOTACTIC METHOD	143	75	13	143		1360			13.54 AANS95
61750	STEREOTACTIC BIOPSY, ASP OR EXCIS OF INTRACRANIAL LESION	70	133		169	1675		16.67	10.03	16.67
62200	THIRD VENTRICULOCISTERNOSTOMY	71	131		172	1851		18.42	13.24	
62200	THIRD VENTRICULOCISTERNOSTOMY	80	120		153		1742			17.33 AANS95
61751	STEREOTACTIC BIOPSY, ASP OR EXCIS OF LESION W COMPUTERIZED AXIAL TOMO	75	187		185	1838		18.29	15.18	18.29

RELATIONSHIP OF 62201 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference procedures for 62201 are 61750 (STEREOTACTIC BIOPSY, INCLUDING BURR HOLES, FOR INTRACRANIAL LESION), with RVW of 10.03 and 61751 (SAME WITH COMPUTERIZED AXIAL TOMOGRAPHY) RVW of 15.18. Since the targeting of 62201 requires a high risk penetration of the floor of the third ventricle near the anterior hypothalamus, the intensity of this procedure is higher than 61751 which supports our recommendation for a RVW of 13.54.

The rank order valuation based on the service times and total work calculation from Harvard3 are appropriate. The MFS95 RVWs are not scaled properly to the relationships within this family of codes, and the translated Harvard3 RVWs provide a more accurate representation of the work involved in each of these services. This supports our recommended RVW of 13.54 for 62201.

CPT Code: 62201

SURVEY DATA:

Specialty: Neurological Surgery

62201	Stats	RVW	LOS Days	PRE-SERVICE Time			INTRA TIME Time	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)				
				Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close		ICU/CCU Visits	Other		Disch Day Mgmt.	Office Visits after discharge		
										to Reco very Room	O.R. Exit		No.x	Time		SUM	No.x	Time
min	10.50	2	45	5	20	30	15	15	0	0	0	0	1	0	15	2	15	30
25th%	16.13	2	79	9	20	53	19	19	0	0	0	0	8	6	19	2	15	30
median	19.00	3	98	13	40	75	20	40	3	5	13	2	13	19	20	3	15	45
75th%	21.50	3	113	15	60	90	20	60	7	13	84	2	15	30	20	4	16	59
max	26.00	3	180	15	60	90	20	60	15	20	300	2	15	30	20	5	20	100
survey n	275																	
RVW resp	4																	
rate %	1%																	

RATIONALE for recommendation:

Work:

Changes in past 5 years

Increasing interest in this procedure as treatment in some forms of hydrocephalus to avoid a shunt procedure.

Rank Order (Ordinal) Valuation:

Rank order meets face validation.

Initial crosswalk or extrapolation misvaluation:

Prev. RUC or Refinement Valuation:

Time:

AANS95 Survey:

Harvard3 Database:

Harvard3 time and work data support rank order & RVWs as listed in table.

Mental Effort & Judgement:

Mental effort in this service comparable to 61750.

Technical Skill & Physical Effort:

Technical skill comparable or slightly less than 61750.

Stress:

Risk factors equivalent to 61750

Intensity/Complexity:

Complexity and intensity same as 61750. Note 3 ICU visits.

Public Comments

Code: 62201

1995 RVUs: 12.1

Recommended RVUs: 15.62

Ratio:

Long Descriptor: Ventriculocisternostomy, third ventricle; stereotactic method

Reference Set (y/n): N

Global Period: 090

Frequency: 12

Impact: 42

Source: 2

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
62201	4	16	100

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
62201	100	100	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
62201	neurological surgery	100

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
62201							
AANS		090	090	15.93	12.10	0.76	12.10

Harvard Data:

Public Comments

30-Jun-95

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
62201								
AANS	12.10	12.10	0.76	1.00	1.00	1.00	15.62	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
62201								
AANS	090	15.93						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
62201									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
62201									
AANS				15.62	12.10	ns	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 62223 Global Period: 090 Current RVW: 12.81 Recommended RVW: 11.96

CPT Descriptor: **Creation of shunt; ventriculo-peritoneal, -pleural, other terminus**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on Key Reference Procedures.**
AANS recommended decrease in RVW from 12.81 to 11.96.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
62192	CREATION OF SHUNT, SUBARACH/SUBDURAL, PERITONEAL, -PLEURAL, OTHER	62	101		108	1023		10.18	11.31	
62223	CREATION OF SHUNT, VENTRICULO-PERITONEAL, -PLEURAL OR OTHER TERMINUS	55	102		150	1224		12.18	12.81	
62223	CREATION OF SHUNT, VENTRICULO-PERITONEAL, -PLEURAL OR OTHER TERMINUS	90	90		140	1202				11.96 AANS94
62220	CREATION SHUNT, VENTRICULO-ATRIAL, JUGULAR -AURICULAR	63	104		110	1076		10.71	12.06	
62258	SHUNT, REMOVAL COMPLETE SYSTEM WITH REPLACEMENT	64	113		112	1108		11.03	13.60	

RELATIONSHIP OF 62223 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

62223 (CREATION OF SHUNT, VENTRICULO-PERITONEAL, -PLEURAL OR OTHER TERMINUS) is a common procedure for diversion of ventricular fluid into other body cavities capable of absorbing and eliminating the excess. It is a key reference procedure that has been believed to be undervalued since the original Harvard/Hsiao study and the 1992 MFS.

For comparison, the original Hsiao/Harvard Phase II total work value for 62223 in November 1990 was 1359. This was reduced at HCFA by June 1992 to 1227, which is comparable to the value listed in the Harvard3 database, and has been the basis for the subsequent RVWs in the MFS. This also indicates a relative overvaluation of work for this service in the original Hsiao project, since our survey data does not support this amount of total work.

The main reference codes are 62192 (CREATION OF SHUNT: SUBARACH/SUBDURAL-PERITONEAL, -PLEURAL, OTHER) and 62258 (SHUNT, REMOVAL COMPLETE SYSTEM WITH REPLACEMENT) which share most of the same elements of work as 62223. The current data indicates that the MFS95 RVWs are significantly higher than those from the Harvard3 process for both of these codes. Our survey indicates the total work value for 62223 in the Harvard3 data was slightly overvalued, and when the lower intensity value from the survey was applied to the survey intra-service time, the resultant work was only 1202. When converted to the scale of the MFS95, the recommended RVW is 11.96.

However, the two reference codes have not been surveyed for detailed time/work/ intensity data and therefore are only useful in the sense of relative valuation of all three codes. When they are rank ordered to one another using MFS95 RVWs, 62223 should be placed between the two codes, than 62258.

CPT Code: 62223

SURVEY DATA:

Specialty: Neurological Surgery

62223	Stats	LOS	PRE-SERVICE TIME			INTRA TIME	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global)				
		Hosp. Stay	Eval before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits			Other Hospital Visits (NOT ICU/CCU)			Disch Day Mgmt.	Office Visits after discharge				
		Days	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM			
	min	0	10	10	0	31	5	0	0	0	0	0	0	0	0	0	10	0	0	10
	25th%	3	30	15	15	60	10	10	0	0	0	2	10	30	15	2	15	33		
	median	4	45	15	30	90	15	15	0	0	0	4	15	60	20	3	45	45		
	75th%	5	60	15	45	100	20	25	0	0	0	4	15	60	30	4	20	60		
	max	8	120	35	90	180	75	120	3	30	60	8	60	240	60	6	30	180		
Intra-time #	105																			
Sample #																				
% response	50%																			

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

The rank order of RVWs listed in the table of procedures in this family has face validity when the AANS94 survey data is used, and supports the placement of the RVW for 62223.

Prev. RUC or Refinement Valuation:

May 1992 panel increased RVW from 13.02 to 13.12.

Time:

Op. Logs:

44 cases with avg. time=86 min.

Anesthesia databases:

467 cases with avg. anesthesia time of 129 minutes

AANS94 Survey Key Refs:

Time and work data used for comparison and scaling with calculation of recommended new RVW.

Harvard3 Database:

See table above.

Mental Effort & Judgement:

The mental effort and judgment are comparable for the three services, except that for initial installation of the ventricular shunt tubing, there is greater judgment and skill required.

Technical Skill & Physical Effort:

The skill of initial installation exceeds that of a removal or replacement procedure.

Stress:

Stress/risk factors are comparable.

Intensity/Complexity:

The intensity/complexity of 62223 as developed from the survey data is lower than the intensity from Harvard3 for 62192 or 62258.

Public Comments

30-Jun-95

Code: 62223

1995 RVUs: 12.81

Recommended RVUs: 13.84

Ratio:

Long Descriptor: Creation of shunt; ventriculo-peritoneal, -pleural, other terminus

Reference Set (y/n): Y

Global Period: 090

Frequency: 4,238

Impact: 4365

Source: 5

Year: 93

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
62223	49.4	7.8	7.9	53.7	6.9	0	1.7	7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
62223	4507	4698	2.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
62223	98.2	98.5	0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
62223	general surgery	3.2
	group practices	4.1
	neurological surgery	89.5
	neurology	2.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
62223	331	20.7	OTHER CEREBRAL DEGENERATIONS
	431	1.1	INTRACEREBRAL HEMORRHAGE

Public Comments30-Jun-95

Harvard Data:

Comm	Modif	Packhw	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
62223							
AANS		090	090	12.43	12.81	1.03	12.36

Harvard Data:

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
62223								
AANS	12.81	12.81	0.99	1.04	1.00	1.00	13.84	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
62223								
AANS	090	12.43		30		102		55

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvie	Offvis
62223									
AANS		1.0		10	6.0		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
62223									
AANS		15		13.84	12.81	ns	n		0.065

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 62268 Global Period: 000 Current RVW: 3.87 Recommended RVW: 4.74

CPT Descriptor: **Percutaneous aspiration, spinal cord cyst or syrinx**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 3.87 to 4.74.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
62284	INJECTION PROCEDURE FOR MYELOGRAPHY, SPINAL OR POST FOSSA	14	25		10	154		1.53	1.54	
62280	INJECTION OF NEUROLYTIC SUBSTANCE, SUBARACHNOID	14	32		11	228		2.27	2.58	
62268	PERCUTAN.ASPIRATION SPINECORD CYST/SYRINX	40	49		16	476		4.74	3.87	4.74
62269	BIOPSY OF SPINAL CORD, PERCUTAN NEEDLE	40	50		19	504		5.02	4.07	5.02
62292	INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS, SINGLE OR MULT, LUMBAR	23	47		83	683		6.80	7.00	
62294	INJECTION PROCEDURE/ARTERIAL/OCCCLUSION AVM SPINAL	41	117		108	1100		10.95	8.05	10.95

RELATIONSHIP OF 62268 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference procedure is 62280 (INJECTION OF NEUROLYTIC SUBSTANCE, SUBARACHNOID) with a RVW of 2.58 and a total work value of 228. 62268 has a total work value of 476, 62269 a work value of 504.

Comparison of the total work values and intra-service times for this group of procedures shows a steady increase in both values with reasonable adherence to the Harvard3 work values when translated to RVWs for 62280 and 62292. However, the RVWs for 62268, 62269 and 62294 were decreased when incorporated into MFS92 and have remained at a level that does not reflect their relative values within their family of procedures.

We recommend that the RVW of 62268 be placed at 4.74 to better represent the true relative value of this service.

RATIONALE for recommendation:

Work:

Changes in past 5 years

A relatively new service, with the advent of reliable imaging (especially MRI) that permits accurate diagnosis and localization of a spinal cord cyst that may be drained by percutaneous aspiration technique.

Rank Order (Ordinal) Valuation:

Ordinal valuation a basic tool for re-establishing relativity in family.

Initial crosswalk or extrapolation misvaluation:

6/91 total work of 328 increased to 476 in 3/92 crosswalk & extrapolat.

Prev. RUC or Refinement Valuation:

Time:

Harvard3 Database:

See table above

Undervalued time/Phase I or II & MFS92:

Time values representative, but conversion from total work to RVWs inaccurate.

Mental Effort & Judgement:

Greater judgment required than for 62280 due to invasion of spinal cord

Technical Skill & Physical Effort:

Greater skill needed to enter cord cyst without additional damage.

Stress:

Risk higher due to danger of hemorrhage in cyst or cord from needle.

Intensity/Complexity:

Intensity higher than 62280.

Public Comments

30-Jun-95

Code: 62268

1995 RVUs: 3.87

Recommended RVUs: 4.74

Ratio:

Long Descriptor: Percutaneous aspiration, spinal cord cyst or syrinx

Reference Set (y/n): N Global Period: 000 Frequency: 73 Impact: 64

Source: 2 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
62268	66.7	66.7	0	33.3	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
62268	87	94	3.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
62268	73.6	55.3	-9.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
62268	anesthesiology	12.8
	group practices	2.1
	internal medicine	2.1
	interventional radiolog	10.6
	neurological surgery	4.3
	orthopedic surgery	4.3
	radiology	61.7
	rehabilitation medicine	2.1

Claims-Level Diagnosis Information:

Public Comments

30-Jun-95

	ICD9	Pct of Time Used	ICD9 Descriptor
62268			
	162	8.3	MALIGNANT NEOPLASM OF TRACHEA, B
	322	8.3	MENINGITIS OF UNSPECIFIED CAUSE
	724	8.3	OTHER AND UNSPECIFIED DISORDERS O

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
62268							
AANS		000	000	4.84	3.87	0.80	3.87

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
62268								
AANS	3.87	3.87	0.80	1.00	1.00	1.00	4.74	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
62268								
AANS	000	4.84		25	*	49		25

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdviedur	Hvis	Svdhvis	Hviedur	Icuvis	Offvis
62268									
AANS	*	0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
62268									
AANS	*	0		4.74	3.87	ns	3		0.075

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 62269 Global Period: 000 Current RVW: 4.07 Recommended RVW: 5.02

CPT Descriptor: **Biopsy of spinal cord, percutaneous needle**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 4.07 to 5.02.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
62284	INJECTION PROCEDURE FOR MYELOGRAPHY SPINAL OR POST FOSSA	14	25		10	154		1.53	1.54	
62280	INJECTION OF NEUROLYTIC SUBSTANCE SUBARACHNOID	14	32		11	228		2.27	2.58	
62268	PERCUTAN ASPIRATION SPINECORD CYST/SYRINX	40	49		16	476		4.74	3.87	4.74
62269	BIOPSY OF SPINAL CORD PERCUTAN NEEDLE	40	50		19	504		5.02	4.07	5.02
62292	INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS, SINGLE OR MULT LUMBAR	23	47		83	683		6.80	7.00	
62294	INJECTION PROCEDURE/ARTERIAL/OCCCLUSION AVM SPINAL	41	117		108	1100		10.95	8.05	10.95

RELATIONSHIP OF 62269 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference procedure is 62280 (INJECTION OF NEUROLYTIC SUBSTANCE, SUBARACHNOID) with a RVW of 2.58 and a total work value of 228. 62268 has a total work value of 476, 62269 a work value of 504.

Comparison of the total work values and intra-service times for this group of procedures shows a steady increase in both values with reasonable adherence to the Harvard3 work values when translated to RVWs for 62280 and 62292. However, the RVWs for 62268, 62269 and 62294 were decreased when incorporated into MFS92 and have remained at a level that does not reflect their relative values within their family of procedures.

We recommend that the RVW of 62269 be placed at 5.02 to better represent the true relative value of this service.

RATIONALE for recommendation:

Work:

Changes in past 5 years

A relatively new service, with the advent of reliable imaging (especially MRI) that permits accurate diagnosis and localization of a spinal cord mass that may be biopsied by percutaneous aspiration technique.

Rank Order (Ordinal) Valuation:

Ordinal valuation a basic tool for re-establishing relativity in family.

Initial crosswalk or extrapolation misvaluation:

6/91 total work of 349 increased to 504 in 3/92 crosswalk/extrapolation.

Prev. RUC or Refinement Valuation:

Time:

Harvard3 Database:

See table above

Undervalued time/Phase I or II & MFS92:

Time values representative, but conversion from total work to RVWs inaccurate.

Mental Effort & Judgement:

Greater judgment required than for 62280 due to invasion of spinal cord

Technical Skill & Physical Effort:

Greater skill needed to enter cord cyst without additional damage.

Stress:

Risk higher due to danger of hemorrhage in cyst or cord from needle.

Intensity/Complexity:

Intensity higher than 62280.

Public Comments30-Jun-95

Code: 62269**1995 RVUs:** 4.07**Recommended RVUs:** 5.02**Ratio:****Long Descriptor:** Biopsy of spinal cord, percutaneous needle**Reference Set (y/n):** N**Global Period:** 000**Frequency:** 227**Impact:** 216**Source:** 2**Year:** 92**Public Comment Letter:** 340**Reference Services:****CMD Comment:**

Societies Wishing to Survey: AANS**Societies Wishing to Comment:** SCVIR**Trends Analysis - Beneficiary Information:**

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
62269	54.5	18.2	9.1	54.5	9.1	0	0	27.3

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
62269	114	270	54.2

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
62269	69.2	50.4	-9.4

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
62269	anesthesiology	20.7
	general surgery	2.2
	group practices	5.2
	interventional radiolog	2.2
	neurological surgery	7.4
	orthopedic surgery	8.1
	radiology	47.4
	rheumatology	5.9

Claims-Level Diagnosis Information:

Public Comments

30-Jun-95

ICD9	Pct of Time Used	ICD9 Descriptor
62269		
199	2.3	MALIGNANT NEOPLASM WITHOUT SPEC
451	2.3	PHLEBITIS AND THROMBOPHLEBITIS
511	2.3	PLEURISY
722	6.8	INTERVERTEBRAL DISC DISORDERS
724	13.6	OTHER AND UNSPECIFIED DISORDERS O
733	2.3	OTHER DISORDERS OF BONE AND CART
780	2.3	GENERAL SYMPTOMS
V72	11.4	SPECIAL INVESTIGATIONS AND EXAMIN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
62269							
AANS		000	000	5.11	4.07	0.80	4.07

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
62269								
AANS	4.07	4.07	0.80	1.00	1.00	1.00	5.02	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notatw	Pret	Svdpre	ltime	Notett	Imppt
62269								
AANS	000	5.11		25	*	50		25

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
62269									
AANS	*	0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
62269									
AANS	*	0		5.02	4.07	ns	3		0.078

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 62287 Global Period: 090 Current RVW: 4.13 Recommended RVW: 7.43

CPT Descriptor: **Aspiration procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 4.13 to 7.43

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 year old male athlete has had 5 weeks of low back pain with sciatica, an absent ankle reflex, and weakness of the posterior calf muscles. He has not responded to anti-inflammatory Rx and restricted activities. He has a history of a previous similar episode that cleared in 3 weeks. An MRI exam shows a diffuse bulging annulus and disk at L5-S1. The patient refuses to accept a laminotomy but agrees to a percutaneous discectomy, which is done in the operating room using a C arm guidance system.

Description of Pre-Service Work: includes review of previous medical records from the earlier episode, and evaluation the imaging studies, and appropriate lab and screening studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup. Positioning is more complex due to the use of a decubitus position and accommodation for the C arm fluoroscope.

Description of Intra-Service Work: The discectomy probe is introduced through the flank and guided into the region of the foramen where it is pushed through the annulus into the disk interspace. Fluoroscopic guidance is required during the insertion and to follow subsequent adjustments in position of the instrument while aspirating and removing disk tissue from the interspace. The probe is removed when no further disk material can safely be removed.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), and monitoring for signs of bleeding. All subsequent visits, including discharge day management are included during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
62284	INJECTION PROCEDURE FOR MYELOGRAPHY, SPINAL OR POST. FOSSA	14	25		10	154		1.53	1.54	
62291	INJECTION PROCEDURE FOR DISCOGRAPHY, SINGLE OR MULT. CERVICAL	18	37		11	261		2.60	2.91	
62290	INJECTION PROCEDURE FOR DISCOGRAPHY SINGLE OR MULT LEVELS LUMBAR	17	35		10	240		2.39	3.58	
62292	INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS, SINGLE OR MULT. LUMBAR	23	47		83	683		6.80	7.00	
62287	PERCUTANEOUS DISCECTOMY	30	60		79	723		7.20	4.13	
62287	PERCUTANEOUS DISCECTOMY	70	60		105		747			7.43 AANS95

RELATIONSHIP OF 62287 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference procedures are 62290 (INJECTION PROCEDURE FOR DISCOGRAPHY, LUMBAR) at RVW 3.58, and 62292 (INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS, INCLUDING DISCOGRAPHY, LUMBAR) at RVW 7.00. The work in 62287 as measured in Harvard3 is 723 compared to the work for 62292 of 683. This indicates that the current RVW of 4.13 is clearly undervalued. The total work in the AANS95 Survey is 747 which converts to the scale of MFS95 at a RVW of 7.43, which is our recommendation.

CPT Code: 62287

SURVEY DATA:

Specialty: **Neurological Surgery**

62287	Stats	RVW	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
			Hosp. Stay	Eval. before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT ICU/CCU)	Disch Day Mgmt.	Office Visits after discharge						
			Days	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM	
	min	7.00	0	10	5	10	30	0	5	0	0	0	0	0	0	10	1	7	7
	25th%	7.00	0	30	15	15	60	10	10	0	0	0	1	10	10	13	2	15	30
	median	8.80	1	45	15	15	60	15	15	0	0	0	1	15	15	15	3	15	45
	75th%	10.50	2	60	15	25	90	15	20	0	0	0	1	15	15	20	3	15	45
	max	15.00	224	120	25	60	100	30	90	0	0	0	3	20	60	30	6	30	180
survey n		275																	
RVW resp		19																	
rate %		7%																	

RATIONALE for recommendation:

Work:

Changes in past 5 years

This procedure has increased substantially in the last 5 years due to new techniques directed to identification of sources of spinal pain.

Rank Order (Ordinal) Valuation:

Rank order valuation basic to relative value apportionment in this set of codes.

Prev. RUC or Refinement Valuation:

MFS92 RVW of 9.29 drastically reduced in May92 refinement to 4.24

Time:

AANS95 Survey:

See table above.

Harvard3 Database:

Original Harvard3 time data appear reasonable; to be confirmed by current survey.

Undervalued time/Phase I or II & MFS92:

Mental Effort & Judgement:

Removal of disk by percutaneous approach requires more pre-service mental effort, and more intra-service judgment than 62290.

Technical Skill & Physical Effort:

Skill higher than 62290, and comparable to 62292.

Stress:

Stress and risk are comparable to 62292.

Intensity/Complexity:

Intensity comparable to 62292.

Public Comments

30-Jun-95

Code: 62287

1995 RVUs: 4.13

Recommended RVUs: 7.00

Ratio:

Long Descriptor: Aspiration procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar

Reference Set (y/n): N Global Period: 090 Frequency: 354 Impact: 1016

Source: 7 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
62287	16.7	0	33.3	50	33.3	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
62287	478	401	-8.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
62287	45.2	41.6	-1.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
62287	anesthesiology	3
	interventional radiolog	3
	neurological surgery	26
	orthopedic surgery	53.4
	radiology	13.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
62287	722	29.2	INTERVERTEBRAL DISC DISORDERS

Public Comments

30-Jun-95

724	4.2	OTHER AND UNSPECIFIED DISORDERS O
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	RatioEh	Mfswk92
62287							
AANS		090	090	7.34	4.13	0.56	8.81

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
62287								
AANS	4.13	4.13	1.20	0.47	1.00	1.00	7.00	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
62287								
AANS	090	7.34						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
62287									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
62287									
AANS				7.00	4.13	ns	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
CMD Comments
Comments on Misvalued Code**

CPT Code: 62290 Global Period: 000 Current RVW: 3.58 Recommended RVW: 3.00

CPT Descriptor: **Injection procedure for diskography, each level; lumbar**

Source and Summary of Comment to HCFA on this service: **CMD Comments and Public Comments by AANS.**
 CMD recommended reduction of RVW from 3.58 to 2.05. AANS recommends reduction to 3.00.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec. New RVW
62289	INJECTION OTHER SUBSTANCE, EPIDURAL OR CAUDAL	15	26		9	161		1.60	1.64	
62291	INJECTION PROCEDURE FOR DISCOGRAPHY, SINGLE OR MULT. CERVICAL	18	37		11	261		2.60	2.91	
62290	INJECTION PROCEDURE FOR DISCOGRAPHY, SINGLE OR MULT. LEVELS LUMBAR	17	35		10	240		2.39	3.58	3.00
62290	INJECTION PROCEDURE FOR DISCOGRAPHY, SINGLE OR MULT. LEVELS LUMBAR	17	35		10	240		2.39	3.58	2.05 CNS/CS
62292	INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS SINGLE OR MULT. LUMBAR	23	47		83	683		6.80	7.00	
62287	PERCUTANEOUS DISKECTOMY	30	60		79	723		7.20	4.13	7.32 AANS/CS

RELATIONSHIP OF 62290 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The CMD comments stated that 62290 has the same pre and post work as 62289, with one third greater intra-service time and slightly more skill, leading to a decision that the RVW of 62289 should be increased by 25% to 2.05 as the RVW proposed for 62290. This analysis has two flaws; first is that selection of 62289 (INJECTION OF SUBSTANCE OTHER THAN ANESTHETIC, CONTRAST, OR NEUROLYTIC SOLUTIONS; LUMBAR OR CAUDAL EPIDURAL (SEPARATE PROCEDURE)) as a reference service for comparison to the service of lumbar diskography is poor. The techniques are not sufficiently comparable and the targets are much different as are the risks of the procedure. Despite similarities in the service times involved, a better choice for comparison would have been 62291 (INJECTION PROCEDURE FOR DISCOGRAPHY, SINGLE OR MULTIPLE, CERVICAL) since it has comparable techniques, skills and risks.

The second flaw was to assume that a 9 minute difference in intra-service time that represents a one third increase in the intra-service time over the reference service 62289 converts to an equivalent change in work. It does not, because the intensity factors for 62289 and 62290 are quite different, leading to work values for the intra-service portion that are different by almost two thirds rather than one third. To extrapolate this difference and apply a 25% adjustment to the existing RVW is inappropriate to correcting the value for this code.

Our review of this problem also reveals that the listed intra-service time for 62290 of 35 minutes is almost certainly for a single level study, despite the descriptor that identifies "single or multiple levels". Our experience with lumbar diskography indicates that an additional level will often double the base time, and it is not unusual for a 2 level study to take over one hour in fluoroscopy to complete. This suggests that the averaging implied by the "single or multiple level" descriptor did not influence the physicians surveyed by the Harvard group in developing this database for 62290, and that the intra-service average time is probably at least 45-50 minutes when the multiple level studies are included. Unfortunately, current survey data are not available, and 62290 does not appear on any of the anesthesia or operative logs that we have used.

To accommodate these concerns, and adjust the RVW for 62290 to relate more reasonably to 62291, it is our recommendation that the RVW be reduced from 3.58 to 3.00. This will allow for the fact that lumbar diskography is inherently more difficult than cervical diskography, and still correct the disproportionate relationship of the present 3.58 value. This also provides a more satisfactory face value for rank order comparisons in this group of procedures.

CMD Comments30-Jun-95

Code: 62290**1995 RVUs:** 3.58**Recommended RVUs:** 2.05**Ratio:** -0.43**Long Descriptor:** Injection procedure for diskography, each level; lumbar**Reference Set (y/n):** N **Global Period:** 000 **Frequency:** 3,739 **Impact:** -5720.67**Source:** 2 **Year:** 92 **Public Comment Letter:****Reference Services:**

	Short Descriptor	RVU	Global
62290			
	62289 INJECTION INTO SPINAL CANAL	1.64	000

CMD Comment:

Has the same pre and post work as 62289, one third greater intraservice time, and slightly more skill. Total is 25% more.

Societies Wishing to Survey:**Societies Wishing to Comment:** AANS, ACR, ASDM**Trends Analysis -- Beneficiary Information:**

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
62290	11	0	9.3	48.3	54.2	0	0.8	6.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
62290	3143	4068	13.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
62290	28.9	15.5	-6.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
62290		
	anesthesiology	13.9
	group practices	6.2
	interventional radiolog	2
	neurological surgery	4.8
	orthopedic surgery	32.4
	radiology	38.5

Claims-Level Diagnosis Information:

CMD Comments

	ICD9	Pct of Time Used	ICD9 Descriptor
62290			
	722	10.6	INTERVERTEBRAL DISC DISORDERS
	724	13.6	OTHER AND UNSPECIFIED DISORDERS O
	729	3.8	OTHER DISORDERS OF SOFT TISSUES
	V72	6.1	SPECIAL INVESTIGATIONS AND EXAMIN

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
62290								
	CMD		ZZZ	000	2.44	3.58	1.47	3.58

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
62290									
	CMD	3.58	3.58	1.47	1.00	1.00	1.00	2.05	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
62290									
	CMD	000	2.44		17	*	35		10

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
62290										
	CMD	*	0.0		0	0.0	*	0	0.0	0.0

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
62290										
	CMD	*	0		2.05	3.58	ns	3		0.052

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 62294 Global Period: 090 Current RVW: 8.05 Recommended RVW: 10.95

CPT Descriptor: **Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended an increase in RVW from 8.05 to 10.95.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
62268	PERCUTAN ASPIRATION SPINECORD CYST/SYRINX	40	49		16	476		4.74	3.87	4.74
62268	BIOPSY OF SPINAL CORD PERCUTAN NEEDLE	40	50		19	504		5.02	4.07	5.02
62292	INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS, SINGLE OR MULT. LUMBAR	23	47		83	683		6.80	7.00	
62294	INJECTION PROCEDURE/ARTERIAL/OCCCLUSION AVM SPINAL	41	117		108	1100		10.95	8.05	10.95

RELATIONSHIP OF 62294 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference services that relate to 62294 (INJECTION PROCEDURE FOR ARTERIAL OCCCLUSION OF A SPINAL CORD VASCULAR MALFORMATION) are 62268 (PERCUTAN.ASPIRATION SPINE CORD CYST/SYRINX) and 62269 (BIOPSY OF SPINAL CORD, PERCUTAN.NEEDLE). Both procedures involve direct invasion of the spinal cord with a needle and entail significant risks, as does 62294. Evaluation of the service times supports the Harvard3 work values which translate to the Harvard4 to MFS95 RVWs. We are recommending that these RVWs based on Harvard3 data be adopted to correct the effects of reductions in the MFS95 RVWs that presently exist.

RATIONALE for recommendation:

Work:	Rank Order (Ordinal) Valuation:	Ordinal values of total work appear correct by face validation.
Time:	Harvard3 Database:	The only available source of time and work reference data for these procedures.
Mental Effort & Judgement:		Substantially more knowledge and judgment required to interfere with the blood supply of the spinal cord therapeutically.
Technical Skill & Physical Effort:		Much training and experience required to minimize rate of complications
Stress:		High stress level due to risk of spinal cord damage from occlusion of blood vessels that supply parts of cord
Intensity/Complexity:		High intensity and complexity, espec. relating to the relative infrequency of the service and highly specialized nature of the techniques.

Public Comments

30-Jun-95

Code: 62294

1995 RVUs: 8.05

Recommended RVUs: 10.95

Ratio:

Long Descriptor: Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal

Reference Set (y/n): N

Global Period: 090

Frequency: 23

Impact: 67

Source: 2

Year: 92

Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS

Societies Wishing to Comment: ACR, SCVIR

Trends Analysis -- Beneficiary Information:

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
62294	17	18	2.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
62294	82.4	55.6	-13.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
62294	anesthesiology	11.1
	other nonphysician prov	11.1
	radiology	77.8

Claims-Level Diagnosis Information:

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
62294							
AANS		090	090	11.17	8.05	0.72	8.05

Public Comments

30-Jun-95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
62294								
AANS	8.05	8.05	0.72	1.00	1.00	1.00	10.95	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
62294								
AANS	090	11.17		33	*	117		22

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
62294									
AANS	*	1.0	*	10	4.5	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
62294									
AANS	*	15	j	10.95	8.05	ns	3		0.058

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION**

CPT Code: 63005 Global Period: 090 Current RVW: 13.53 Recommended RVW: 13.88

CPT Descriptor: Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis

Source and Summary of Comment to HCFA on this service: Public Comments by AANS.
AANS recommended an increase in RVW from 13.53 to 13.88. AANS 95 survey in progress.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year male athlete has had 6 months of low back pain with radiation into both upper legs that is notably induced or aggravated by walking only one block. It is slowly growing worse, and he has lost some strength in his left leg. He has not responded to anti-inflammatory Rx and restricted activities. An MRI exam shows a multiple diffuse bulging disks with osteophytes at L2-3, L3-4, and L4-L5. The sagittal canal depth at L3-4 is 7 mm and 8 mm at L4-5. The patient consents to a decompressive laminectomy at the lower two levels.

Description of Pre-Service Work: includes review of previous medical history, evaluation of the imaging studies, and appropriate lab and screening studies. Pre-service work includes informed consent with the patient and family, plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup. Positioning is prone on a frame to avoid compression of the abdominal contents.

Description of Intra-Service Work: The incision is in the lumbar midline from L2 to L5. The fascia and muscles are released from the bony attachments and retracted laterally. A localizing lateral X-ray is made for identification of the correct levels. The spinous process and lamina of L3, L4 and the upper portion of L5 are removed bilaterally. Overhanging portions of the hypertrophic facets are removed without total facetectomy. No disk removal is required. After decompression of the dural sac and cauda equina, hemostasis is confirmed and the muscle and fascial layers are closed. A drain may be left in the epidural space. The skin is closed and dressings applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of bleeding. All hospital visits and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	Hrvd3 Wrk/min
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS LUMBAR ONE LEVEL	66	121		114	1282		12.76	12.76	Benchmark Procedure	6.63
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS LUMBAR ONE LEVEL	85	120		140		1364			13.87 AANS94	6.22 AANS94
63005	LAMINECTOMY/EXPL/DECOMP CORD & OR CAUDA EQUINA 1 OR 2 SEGS LUMBAR, EXC SPONDYLOLIS	62	142		157	1487		14.80	13.53		6.17
63005	LAMINECTOMY/EXPL/DECOMP CORD & OR CAUDA EQUINA 1 OR 2 SEGS LUMBAR, EXC SPONDYLOLIS	85	142		160		1394			13.88 AANS95	4.98 AANS95
63012	LAMINECTOMY DECOMPR CAUDA EQUINA FOR SPONDYLOLISTHESIS (GILL)	69	140		137	1434		14.27	14.21		6.24
63003	LAMINECTOMY FOR EXPLORATION/DECOMP CORD 1 OR 2 SEGS THORACIC	68	127		144	1472		14.65	14.63		6.64
63017	LAMINECTOMY/EXPL/DECOMP LUMBAR CORD OR CAUDA EQUINA > 2 SEGS	72	168		152	1673	1592	16.65	15.85		6.31
63017	LAMINECTOMY/EXPL/DECOMP LUMBAR CORD OR CAUDA EQUINA > 2 SEGS	90	150		145		1498			14.90 AANS94	5.68 AANS94

CPT Code: 63005

RELATIONSHIP OF 63005 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The reference procedure is 63047 (LAMINECTOMY/COMPLETE DECOMPRESSION FOR STENOSIS, LUMBAR, ONE LEVEL). The total work value is 1282 and the intra-service time 121 minutes from Harvard3. The Harvard3 total work for 63005 is 1487 and the intra-service time 142 minutes. This time and work difference compared to 63047 supports our recommendation for a higher RVW than the present 13.53. When the data from our current survey for 63005 is included, the times are changed slightly along with a reduced intensity factor from 6.17 to 4.98 with the result that the total work value declines to 1394. When this is converted to the MFS95 scale, the recommended RVW for 63005 is 13.88.

An additional comparison is that 63047 is limited to a decompressive laminectomy at a single lumbar level, while 63005 may include removal of a lamina at an adjacent second level. This adds incrementally to the intra-service work, and the listed difference of 21 minutes is reasonable to cover that additional work.

The original MFS92 RVW for 63005 was 15.52. This was reduced to 13.86 in the May92 Refinement Panel based on that Panel's recommendations. We suspect that the reduction was based upon the downward adjustment imposed on the original Hsiao Phase II total work value of 1581 which would have translated to a RVW of about 15.52. After this work value was delivered to HCFA, there was an unexplained reduction to 1469, which is the value that appeared in the June 1992 and Harvard3 databases.

The AANS95 Survey data on 63005 provides a total work value of 1394, which when translated to the scale of the MFS95 results in a RVW of 13.88. This value fits into the rank order scale of values in this family of procedures and is our recommendation to correct this misvalued code.

SURVEY DATA:

Specialty: Neurological Surgery

63005	Stats	RVW	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)						
			Hosp.	Eval.	Scrub	O.R. Entry to	Skin Open to	Skin Close to	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)	Dischg Day	Office Visits after								
			Stay	O.R.	Dress	Skin Open	Skin Close	O.R. Exit	Recovery Room	Visits	Mgmt.	discharge								
			Days	Time	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM	
	min	10.00	2	15	10	10	60	5	0	0	0	0	1	5	5	10	1	6	6	
	25th%	14.00	3	30	15	20	120	15	14	0	0	0	3	10	30	15	2	15	30	
	median	14.90	4	45	15	25	143	20	15	0	0	0	4	15	60	20	3	15	45	
	75th%	15.00	4	60	15	30	180	30	20	0	0	0	5	15	75	21	4	20	80	
	max	15.85	7	150	40	45	240	60	90	1	15	15	8	25	200	60	6	30	180	
Survey n	275																			
RVW resp	40																			
rate %	15%																			

RATIONALE for recommendation:

Work:
Rank Order (Ordinal) Valuation: Rank order of boldface RVWs as listed in table above appropriate.
Initial crosswalk or extrapolation misvaluation: Original Hsiao/Harvard Phase II total work value of 1581 in 11/90 was reduced at HCFA in 6/91 to 1469. Initial crosswalk total work value was 1487 in Harvard3.
Prev. RUC or Refinement Valuation: May92 Refinement changed RVW from 15.62 to 13.86.

Time:
Op. Logs: 3 cases; avg. time = 202 min.
Anesthesia databases: 7069 combined cases; avg. anesth. time = 178 min.
69 cases; avg. anesth. time = 223 min.
AANS95 Survey: Survey data used in above recommendations.
Harvard3 Database: The times in the Harvard3 database appear to represent reasonable relativity in this set of codes when no current survey data available..
Undervalued time/Phase I or II & MFS92: It appears tha the original RVW of 15.62 was actually overvalued, and that the Refinement panel came remarkably close to the scale of the current survey data by reducing it below the Harvard3 recommendation. Comparable across this group of procedures.

Mental Effort & Judgement: Comparable within group
Technical Skill & Physical Effort: Stress and risk higher for cervical and re-operation procedures.
Stress: The intensity factors as listed within this family of codes from Harvard3 were relatively good. The changes from our survey of intensity simply adjust some of the codes in their relation to the family and provide validation to the basic Harvard3 numbers.
Intensity/Complexity:

Public Comments

30-Jun-95

Code: 63005

1995 RVUs: 13.53

Recommended RVUs: 14.80

Ratio:

Long Descriptor: Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 2,991 **Impact:** 3799

Source: 6 **Year:** 93 **Public Comment Letter:** 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS, AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63005	46.7	6.7	1.4	66.7	6.7	0	0	8.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63005	4635	3215	-16.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63005	96.2	95.5	-0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63005	group practices	2.6
	neurological surgery	58
	orthopedic surgery	35.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63005	721	1	SPONDYLOSIS AND ALLIED DISORDERS
	722	7.3	INTERVERTEBRAL DISC DISORDERS
	724	21	OTHER AND UNSPECIFIED DISORDERS O

Public Comments

30-Jun-95

727	1.3	OTHER DISORDERS OF SYNOVIUM, TEN
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63005							
AANS		090	090	15.10	13.53	0.90	14.83

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
63005								
AANS	13.53	13.53	0.98	0.91	1.00	1.00	14.80	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
63005								
AANS	090	15.10		32		142		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	icvis	Offvis
63005									
AANS		1.0		10	5.5		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
63005									
AANS		15		14.80	13.53	xx	n		0.063

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 63011 Global Period: 090 Current RVW: 11.11 Recommended RVW: 13.40

CPT Descriptor: **Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; sacral**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 11.11 to 13.40.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
63709	REPAIR OF DURAL/CSF LEAK OR PSEUDOMENINGOCOELE WITH LAMINECTOMY	69	146		126	1289		12.83	13.26	
63011	LAMINECTOMY/SACRAL REGION	68	126		132	1346		13.40	11.11	13.40
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS LUMBAR, ONE LEVEL	66	121		114	1282		12.76	12.76	Benchmark Procedure
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS, LUMBAR, ONE LEVEL	85	120		140		1364			13.57 AANS94
63005	LAMINECTOMY/EXPL/DECOMP CORD &/OR CAUDA EQUINA 1 OR 2 SEGS LUMBAR	62	142		157	1487		14.80	13.53	
63005	LAMINECTOMY/EXPL/DECOMP CORD &/OR CAUDA EQUINA, 1 OR 2 SEGS, LUMBAR	85	142		160		1394			13.88 AANS95
63012	LAMINECTOMY, DECOMPR CAUDA EQUINA, FOR SPONDYLOLISTHESIS (GILL)	69	140		137	1434		14.27	14.21	

RELATIONSHIP OF 63011 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

63011 (LAMINECTOMY, SACRAL REGION) involves removal of the bony covering over the spinal canal that extends into the upper sacrum, which is similar in technique and approach to 63047 (LAMINECTOMY/COMPLETE DECOMPR STENOSIS, LUMBAR, ONE LEVEL). 63011 has a Harvard3 total work value of 1346 based on slightly greater intra- and post-service times than 63047 or 63709. The original MFS92 had a RVW of 13.62 for 63011, which was reduced to 11.38 based on the May92 Refinement Panel recommendations. It has not been adjusted subsequently other than from budget neutrality changes, thence is presently at 11.11. This is low related to the time and work data available from Harvard3 that supports a higher RVW. The reference procedure is 63709 REPAIR OF DURAL/CSF LEAK OR PSEUDOMENINGOCOELE, WITH LAMINECTOMY with a total work value from Harvard3 of 1289 and an intra-service time of 146 minutes. The total work value for 63011 is 1346 and time is 126 minutes. This places 63011 at slightly more total work then the reference service, and supports our recommendation for an increase in RVW to 13.40. Reference to the Harvard3 data also supports this recommendation, since that is the value originally accepted (before adjustments) and is the translation RVW from the Harvard3 total work value.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:	Rank order valuation appropriate as listed in the table above.
Initial crosswalk or extrapolation misvaluation:	Initial total work of 1284 increased to 1364.
Prev. RUC or Refinement Valuation:	Refinement Panel reduction noted above in MFS92.

Time:

Anesthesia databases:	2 cases; avg. anesth. time = 171 min.
Harvard3 Database:	See above.

Mental Effort & Judgement:

Technical Skill & Physical Effort:

Technique similar to 63709

Public Comments

30-Jun-95

Code: 63011 1995 RVUs: 11.11 Recommended RVUs: 13.40 Ratio:

Long Descriptor: Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), one or two vertebral segments; sacral

Reference Set (y/n): N Global Period: 090 Frequency: 41 Impact: 94

Source: 6 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS, AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63011	0	0		100	0	0	0	

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63011	26	50	38.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63011	76.9	96	9.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63011	neurological surgery	64
	neurology	4
	orthopedic surgery	32

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63011	724	25	OTHER AND UNSPECIFIED DISORDERS O

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63011							
AANS		090	090	13.67	11.11	0.81	12.94

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
63011								
AANS	11.11	11.11	0.95	0.86	1.00	1.00	13.40	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
63011								
AANS	090	13.67		34	*	126		50

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
63011									
AANS	*	1.0	*	10	6.0	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
63011									
AANS	*	15		13.40	11.11	ns	3		0.065

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 63015 Global Period: 090 Current RVW: 16.59 Recommended RVW: 17.77

CPT Descriptor: **Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS for Key Reference Procedure. AANS recommended increase in RVW from 16.59 to 17.77.**

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVW's			Intensity Hrvd3 Wrk/min
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	
63048	LAMINECTOMY/COMPLETE DECOMPR STENOSIS EA ADDTL SEGMENT ANY LEVEL								3.26		
63001	LAMINECTOMY FOR EXPLORATION/DECOMP CORD 1 OR 2 SEGS CERVICAL	71	127		143	1461		14.54	14.50		6.57
63003	LAMINECTOMY FOR EXPLORATION/DECOMP CORD 1 OR 2 SEGS THORACIC	66	127		144	1472		14.65	14.63		6.64
63016	LAMINECTOMY FOR EXPLORATION/DECOMP THORACIC CORD > 2 SEGS	128	162		155	1790		17.82	17.43		6.80
63015	LAMINECTOMY FOR EXPLORATION/DECOMP CERVICAL CORD > 2 SEGS	59	161		142	1763		17.55	16.59		7.17
63015	LAMINECTOMY FOR EXPLORATION/DECOMP CERVICAL CORD > 2 SEGS	90	150	21	166		1785		16.59	17.77 AANS94	7.00 AANS94

RELATIONSHIP OF 63015 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

63015 (LAMINECTOMY FOR EXPLORATION/DECOMP. CERVICAL CORD, > 2 SEGS) involves a decompressive laminectomy of the cervical canal and contents for more than two vertebral segments, and usually includes 3 or 4 lamina to decompress a stenotic spinal canal. The reference service of most relevance is 63001 (LAMINECTOMY FOR EXPLORATION/DECOMP CORD, 1 OR 2 SEGS, CERVICAL) which is the same service limited to 1 or 2 lamina or segments. The additional laminectomy is covered in 63048 (LAMINECTOMY/COMPLETE DECOMPR. STENOSIS, EA ADDTL SEGMENT, ANY LEVEL) with a RVW of 3.26 and no previous Harvard3 time/work values.

If the RVWs from these two reference services are combined, 63001 with a RVW of 14.50 + 63048 RVW of 3.26 = 17.76 for the combination, which is a close approximation to the RVW of 17.77 recommended by the AANS for 63015.

Comparison of the time and work values is helpful in this family. Note that the Pre- and Post-service times for 63015 are significantly higher in the AANS94 survey than from the Harvard3 data, while Intra-service time is slightly less. The net result is a work value derived from the calculations of AANS94 surveyed time that is 1810 compared to the Harvard3 work value of 1763. This would ordinarily translate to a RVW of 17.55 rather than the present RVW of 16.59 which reflects the degradation of work values from budget neutrality changes. We recommend that the RVW be 17.77 to restore relativity to this service.

CPT Code: 63015

SURVEY DATA:

Specialty: Neurological Surgery

63015	Stats	LOS		PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS							OFFICE VISITS (thru global)				
		Days	Time	Time	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM
min	2	10	10	9	15	5	5	0	0	0	2	5	20	10	1	10	10		
25th%	4	30	15	20	120	15	10	0	0	0	3	10	40	20	2	15	40		
median	5	45	15	30	180	20	10	0	0	0	4	15	60	23	3	15	45		
75th%	5	60	15	45	180	26	30	0	0	0	5	15	76	30	3	20	60		
max	8	180	35	111	350	120	120	4	25	80	9	90	540	75	10	30	180		

Intra-time #	96
Sample #	209
% response	46%

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:
 Initial crosswalk or extrapolation misvaluation:
 Prev. RUC or Refinement Valuation:

Rank order for boldface RVWs appropriate as listed in the table above.
 6/91 total work = 1647; 3/92 total work = 1763
 No identified refinement changes.

Time:

Op. Logs:
 Anesthesia databases:
 AANS94 Survey Key Refs:
 Harvard3 Database:

4cases; avg. time = 135 min.
 44 cases; avg. anesth. time = 185 min.
 See comments above.
 Time and work data still valid.

Mental Effort & Judgment:
 Technical Skill & Physical Effort:
 Stress:

Comparable across this group of procedures.
 Comparable within group

Intensity/Complexity:

Higher for this and other cervical and thoracic procedures, due to proximity of spinal cord and potential for major complications.
 The intensity factors as listed within this family of codes from Harvard3 were relatively good. The changes from our survey of intensity simply adjust some of the codes in their relation to the family and provide validation to the basic Harvard3 numbers.

Public Comments

30-Jun-95

Code: 63015

1995 RVUs: 16.59

Recommended RVUs: 17.55

Ratio:

Long Descriptor: Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical

Reference Set (y/n): N Global Period: 090 Frequency: 1,275 Impact: 1224

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS, AAOS

Societies Wishing to Comment:

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63015	36.4	10.9	18.2	20	14.5	3.6	0	3.8

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
63015	1399	1341	-2.1

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63015	97.1	97.6	0.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
63015	group practices	5.5
	neurological surgery	84.6
	orthopedic surgery	6.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63015	721	9.8	SPONDYLOSIS AND ALLIED DISORDERS
	722	1.8	INTERVERTEBRAL DISC DISORDERS
	723	15.2	OTHER DISORDERS OF CERVICAL REGIO

Public Comments

30-Jun-95

724	2.7	OTHER AND UNSPECIFIED DISORDERS O
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63015							
AANS		090	090	17.90	16.59	0.93	16.59

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
63015								
AANS	16.59	16.59	0.93	1.00	1.00	1.00	17.55	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
63015								
AANS	090	17.90		34		161		45

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
63015									
AANS		1.0		10	7.5		10	3.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
63015									
AANS		15		17.55	16.59	ns	3		0.073

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 63017 Global Period: 090 Current RVW: 15.85 Recommended RVW: 14.90

CPT Descriptor: **Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; lumbar**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on Key Reference Procedure.**
AANS recommended decrease in RVW from 15.85 to 14.90.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Hr/d3 Wrk/min
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hr/d3	AANS	Hr/d3 to MFS95	MFS95	Rec.New RVW	
63048	LAMINECTOMY/COMPLETE DECOMPR STENOSIS EA ADDTL SEGMENT ANY LEVEL								3.26		
63017	LAMINECTOMY/COMPLETE DECOMPR STENOSIS LUMBAR ONE LEVEL	66	121		114	1282		12.76	12.76	Benchmark Procedure	6.63
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS LUMBAR ONE LEVEL	85	120		140		1364			13.57 AANS94	6.22 AANS94
63005	LAMINECTOMY/EXPL/DECOMP CORD & OR CAUDA EQUINA 1 OR 2 SEGS LUMBAR, EXC SPONDYLOLIS	62	142		157	1487		14.80	13.53		6.17
63005	LAMINECTOMY/EXPL/DECOMP CORD & OR CAUDA EQUINA 1 OR 2 SEGS LUMBAR, EXC SPONDYLOLIS	85	142		163		1394			13.88 AANS95	4.98 AANS95
63017	LAMINECTOMY/EXPL/DECOMP LUMBAR CORD OR CAUDA EQUINA > 2 SEGS	72	168		152	1673		16.65	15.85		6.31
63017	LAMINECTOMY/EXPL/DECOMP LUMBAR CORD OR CAUDA EQUINA > 2 SEGS	90	150		145		1498			14.90 AANS94	5.68 AANS94
63016	LAMINECTOMY FOR EXPLORATION/DECOMP THORACIC CORD > 2 SEGS	126	162		155	1790		17.82	17.43		6.80
63015	LAMINECTOMY FOR EXPLORATION/DECOMP CERVICAL CORD > 2 SEGS	59	161		142	1763		17.55	16.59		7.17
63015	LAMINECTOMY FOR EXPLORATION/DECOMP CERVICAL CORD > 2 SEGS	90	150	21	166		1786		16.59	17.77 AANS94	7.00 AANS94

RELATIONSHIP OF 63017 TO KEY REFERENCE SERVICES and Other Rationales for RVW Recommendation:

63017 (LAMINECTOMY FOR EXPLORATION/DECOMP. LUMBAR CORD OR CAUDA EQUINA, > 2 SEGS) involves a decompressive laminectomy of the lumbar canal and contents for more than two vertebral segments, and usually includes 3 or 4 lamina to decompress a stenotic spinal canal. The reference service of most relevance is 63005 (LAMINECTOMY FOR EXPLORATION/DECOMP CORD, 1 OR 2 SEGS, LUMBAR) which is the same service limited to 1 or 2 lamina or segments. The additional laminectomy is covered in 63048 (LAMINECTOMY/COMPLETE DECOMPR. STENOSIS, EA. ADDTL SEGMENT, ANY LEVEL) with a RVW of 3.26 and no previous Harvard3 time/work values.

If the RVWs from these two reference services are combined, 63005 with a RVW of 13.88 + 63048 RVW of 3.26 = 17.24 for the combination, which is substantially more than the RVW of 14.90 recommended by the AANS for 63017. When the basis for this difference is examined, the total work value of 1498 for 63017 from the survey is greater than the Harvard3 total work for 63005 of 1394. However, the intensity factors are significantly different, with the survey intensity for 63017 at 5.68 compared to the Harvard3 intensity for the same service at 6.31. This reduction, when applied to the computation of a total work value for the time values surveyed results in the lower total work of 1498, which then translates to a RVW of 14.90.

This reduced intensity factor is derived from the survey which compared the components of intensity for each of the three components used in the MFS as well as the three phases of service, pre- intra- and post-service times. This provided a prospective and provider based approach to a more rational use of intensity as a key component of the total work and thence, RVWs that represent a particular service.

CPT Code: 63017

SURVEY DATA:

Specialty: **Neurological Surgery**

63017	Stats	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global)		
			Hosp. Stay	Eval before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT icu/ccu)			Dischg Day Mgmt	Office Visits after discharge		
		Days	Time	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM
	min	2	10	10	9	15	5	5	0	0	0	1	5	10	10	0	0	10
	25th%	3	30	15	15	120	10	10	0	0	0	3	10	30	15	2	15	45
	median	4	45	15	30	180	15	15	0	0	0	4	15	60	20	3	15	45
	75th%	5	60	15	30	180	20	25	0	0	0	5	15	80	30	4	20	60
	max	7	180	35	82	240	180	120	2	20	40	9	60	240	60	10	30	150
Intra-time #		103																
Sample #																		
% response		49%																

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:
Initial misvaluation:

Boldface RVW values in table meet face validation.
Original Hsiao Phase II total work from 11/90 was 1719. This was reduced by HCFA in 6/91 to a total work value of 1665. This was then increased to 1667 in the Phase3 extrapolation.
The original MFS92 RVW for 63017 was 17.51, but the May92 Refinement Panel reduced total work from 17.51 to 16.24.

Prev. RUC or Refinement Valuation:

Time:

Op. Logs:
Anesthesia databases:
AANS94 Survey Key Refs:
Harvard3 Database:

2 cases; avg. time = 170 mmin
111 cases; avg. anesth. time 213 min.
See table and comments above
Time data still quite appropriate.

Mental Effort & Judgement:
Technical Skill & Physical Effort:
Stress:
Intensity/Complexity:

Comparable to ref. services.
Slightly more effort than ref. services due to greater extent of surgery.
Stress factors approx. the same.
See above for intensity factors.

Public Comments

30-Jun-95

Code: 63017

1995 RVUs: 15.85

Recommended RVUs: 16.86

Ratio:

Long Descriptor: Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg. spinal stenosis), more than 2 vertebral segments; lumbar

Reference Set (y/n): Y Global Period: 090 Frequency: 3,184 Impact: 3216

Source: 6 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS, AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63017	40	2.5	6.3	48.8	8.8	0	0	7.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63017	4502	3389	-13.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63017	97.5	98.2	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63017	neurological surgery	66.1
	orthopedic surgery	30

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63017	721	2.5	SPONDYLOSIS AND ALLIED DISORDERS
	722	5.3	INTERVERTEBRAL DISC DISORDERS
	724	22.2	OTHER AND UNSPECIFIED DISORDERS O

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhw	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63017							
AANS		090	090	16.98	15.85	0.93	16.62

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
63017								
AANS	15.85	15.85	0.98	0.95	1.00	1.00	16.86	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
63017								
AANS	090	16.98		36		168		60

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
63017									
AANS		1.0		10	7.0		10	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
63017									
AANS		15		16.86	15.85	xx	n		0.064

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 63020 Global Period: 090 Current RVW: 12.53 Recommended RVW: 13.77

CPT Descriptor: **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on a Key Reference Procedure. AANS recommended changes to the RVW to Increase from 12.53 to 13.77.**

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Hrwd3 Wrk/min
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrwd3	AANS	Hrwd3 to MFS95	MFS95	Rec. New RVW	
63030	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, LUMBAR	63	91		125	1080		10.75	12.11	*	6.31
63030	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, LUMBAR	75	90		143	1115				11.10 AANS94	5.68 AANS94
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS, LUMBAR, ONE LEVEL	66	121		114	1282		12.76	12.76	Benchmark Procedure	6.63
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS, LUMBAR, ONE LEVEL	85	120		140	1364				13.57 AANS94	6.22 AANS94
63020	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, CERVICAL	108	129		107	1262		12.56	12.53		6.27
63020	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, CERVICAL	90	120		145	1384				13.77 AANS94	6.17 AANS94
63005	LAMINECTOMY/EXPL/DECOMP CORD &/OR CAUDA EQUINA, 1 OR 2 SEGS, LUMBAR, EXC SPONDYLOSIS	62	142		157	1487		14.80	13.53		6.17
63017	LAMINECTOMY/EXPL/DECOMP CORD &/OR CAUDA EQUINA, 1 OR 2 SEGS, LUMBAR, EXC SPONDYLOSIS	85	142		160	1394				13.88 AANS95	4.98 AANS95
63017	LAMINECTOMY/EXPL/DECOMP LUMBAR CORD OR CAUDA EQUINA, > 2 SEGS	72	168		152	1673		16.65	15.85		6.31
63017	LAMINECTOMY/EXPL/DECOMP LUMBAR CORD OR CAUDA EQUINA, > 2 SEGS	90	150		145	1498				14.80 AANS94	5.68 AANS94

RELATIONSHIP OF 63020 TO KEY REFERENCE SERVICES and Other Rationales for RVW Recommendation:

63020 (LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, CERVICAL) is a common surgical service provided to patients with a ruptured cervical disk that requires decompressive surgery and disk excision. It is compared to 63030 (LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, LUMBAR) except that this reference procedure involves less pre- and intra-service time with significantly less total work of 1115. This is reflected in the RVW of 11.10 for 63030. The time and work values for 63020 are greater than 63030 except for post-service work, and the total work for 63030 from the survey is 1115 compared to the survey data of total work of 1384 for 63020. Consequently, the RVW for 63020 should be more than that of 63030 to reflect the greater amount of total work.

The Harvard3 data for 63020 translates to a 1995 RVW of 12.53, while the AANS94 survey of 63020 gives a RVW of 13.77. This survey data is both current and broad based, with confirmation of the intra-service time data from operative logs and anesthesia time databases. When the surveyed total work for 63020 of 1384 is translated to the MFS95, the recommended RVW is 13.88.

PT Code: 63020

SURVEY DATA:

Specialty: Neurological Surgery

63030	Stats	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
			Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to Reco very O.R. Ext.	ICU/CCU Visits	Other Hospital Visits (NOT ICU/CCU)	Disch Day Mgmt.	Office Visits after discharge					
		Days	Time	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM
	min	1	10	10	9	15	5	1	0	0	0	1	5	15	2	1	10	10
	25th%	2	30	15	20	90	10	10	0	0	0	2	10	30	20	2	15	40
	median	2	45	15	30	120	20	15	0	0	0	3	15	45	20	3	15	45
	75th%	4	60	15	45	150	25	20	0	0	0	4	15	60	30	3	20	60
	max	6	180	35	105	210	75	120	50	20	20	10	30	120	60	6	30	120
	Intra-time #	89																
	Sample #																	
	% response	43																

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Rank order of boldface RVWs appropriate as depicted in the table above.

Initial crosswalk or extrapolation misvaluation:

Crosswalk value for total work= 1262.

Time:

Op. Logs:

20 cases; avg. time = 99 min.

Anesthesia databases:

279 cases; avg. anesthesia time = 189 min.

AANS94 Survey Key Refs:

Procedure surveyed with results described above.

Harvard3 Database:

See table above for data.

Mental Effort & Judgement:

Rated slightly above 63030.

Technical Skill & Physical Effort:

Rated above 63030 and the below 63047.

Stress:

Rated slightly above 63030 but very slightly above 63047.

Intensity/Complexity:

Intensity factor of 6.17 compared to 63030 of 5.68 or 63047 of 6.22.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 63030 Global Period: 090 Current RVW: 12.11 Recommended RVW: 11.10

CPT Descriptor: **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on a Key Reference Procedure. AANS recommended changes to the RVW to decrease from 12.11 to 11.10.**

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Wrk/min
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	
63030	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, LUMBAR	63	91		125	1080		10.75	12.11	*	6.31
63030	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, LUMBAR	75	90		143		1115			11.10 AANS94	5.68 AANS94
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS, LUMBAR, ONE LEVEL	66	121		114	1282		12.76	12.76	Benchmark Procedure	6.63
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS, LUMBAR, ONE LEVEL	85	120		140		1364			13.57 AANS94	6.22 AANS94
63020	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISC, UNILATERAL, CERVICAL	108	129		107	1262		12.56	12.53		6.27
63020	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISC, UNILATERAL, CERVICAL	90	120		145		1384			13.77 AANS94	6.17 AANS94
63005	LAMINECTOMY/EXPL/DECOMP CORD &/OR CAUDA EQUINA 1 OR 2 SEGS, LUMBAR, EXC SPONDYLOUS	62	142		157	1487		14.80	13.53		6.17
63017	LAMINECTOMY/EXPL/DECOMP CORD &/OR CAUDA EQUINA > 2 SEGS, LUMBAR, EXC SPONDYLOUS	85	142		160		1394			13.88 AANS94	4.98 AANS94
63017	LAMINECTOMY/EXPL/DECOMP LUMBAR CORD OR CAUDA EQUINA > 2 SEGS	72	168		152	1673		16.65	15.85		6.31
63017	LAMINECTOMY/EXPL/DECOMP LUMBAR CORD OR CAUDA EQUINA > 2 SEGS	90	150		145		1498			14.90 AANS94	5.68 AANS94

RELATIONSHIP OF 63030 TO KEY REFERENCE SERVICES and Other Rationales for RVW Recommendation:

63030 (LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, LUMBAR) is a common surgical service provided to patients with a ruptured lumbar disk that requires decompressive surgery and disk excision. It is compared to 63020 (LAMINOTOMY, ONE LEVEL FOR HERNIATED DISC, UNILATERAL, CERVICAL) except that this reference procedure involves more pre- and intra-service time with significantly more total work of 1384. This is reflected in the recommended RVW of 13.77 for 63020. The time and work values for 63020 are greater than 63030 except for post-service work, and the total work for 63030 from the survey is 1115 compared to the survey data of total work of 1384 for 63020. Consequently, the RVW for 63030 should be less than that of 63020 to reflect the lesser amount of total work.

The Harvard3 data for 63030 translates to a 1995 RVW of 10.75, while the AANS94 survey of 63030 gives a RVW of 11.10. This survey data is both current and broad based, with confirmation of the intra-service time data from operative logs and anesthesia time databases. The present MFS95 RVW of 12.11 was the result of a Refinement Panel change made in May 1992 when the original value of 11.46 was increased to 12.40. It has since declined to 12.11 with budget neutrality adjustments. The problem posed by that increase was that 63030 and its original RVW of 11.46 were the benchmark for all neurosurgery codes, and shifting the RVW upward by 11% should have changed every other value proportionately in the same direction. Those changes did not happen and that left 63030 as an anomalous value while voiding the benchmark against which all the other procedures in the neurosurgical code section had been measured or estimated.

If the resource based methodology of developing and supporting changes in the relative values for different services is to be maintained as designed, then it is necessary to be consistent in application of that methodology to revisions in the 5 Year Review and in particular, in the case of 63030. Despite the apparent arbitrary changes made to the RVW in 1992, the original data and now current survey of the same procedure support a lower value. Therefore, we recommend a RVW of 11.10.

CPT Code: 63030

SURVEY DATA:

Specialty: Neurological Surgery

63030	Stats	LOS	PRE-SERVICE TIME			INTRA TIME	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global)			
			Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Room Exit	ICU/CCU Visits			Other Hospital Visits (NOT icu/ccu)			Disch Day Mgmt	Office Visits after discharge		
				Days	Time		Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM
	min	0	5	10	9	30	5	5	0	0	0	1	5	5	0	1	10	10	
	25th%	2	30	15	15	75	10	10	0	0	0	2	10	20	15	2	15	40	
	median	2	30	15	30	90	15	15	0	0	0	3	15	45	20	3	15	48	
	75th%	3	60	15	40	120	20	20	0	0	0	4	15	60	30	3	20	60	
	max	5	180	35	75	180	45	120	0	0	0	8	40	120	60	10	30	150	
Intra-time #	105																		
Sample #																			
% response	50%																		

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation:

Rank order of boldface RVWs appropriate as depicted in the table above.

Initial crosswalk or extrapolation misvaluation:

Original Hsiao Phase II total work in 11/90 was 1181. This was reduced to 1080 at HCFA by 6/91, which was the initial crosswalk work value. May92 Refinement Panel increased RVW from 11.46 to 12.40.

Prev. Refinement Panel:

Time:

Op. Logs:

248 cases; avg. time = 98 min.

Anesthesia databases:

2709 cases; avg. anesthesia time = 155 min.

AANS94 Survey Key Refs:

Procedure surveyed with results described above.

Harvard3 Database:

See table above for data.

Mental Effort & Judgement:

Rated slightly below 63020.

Technical Skill & Physical Effort:

Rated slightly above 6300 and the same as 63047.

Stress:

Rated slightly above 63020 but the same as 63047.

Intensity/Complexity:

Intensity factor of 5.68 compared to 63020 of 6.17 or 63047 of 6.22.

Public Comments

30-Jun-95

Code: 63030

1995 RVUs: 12.11

Recommended RVUs: 13.90

Ratio:

Long Descriptor: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar

Reference Set (y/n): Y Global Period: 090 Frequency: 24,026 Impact: 43007

Source: 5 Year: 93 Public Comment Letter: 185

Reference Services:

CMD Comment:

Societies Wishing to Survey: AANS, AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63030	29.7	2.2	6.4	52.6	14.4	0	0.3	10.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63030	29413	29103	-0.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63030	97.2	97.4	0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63030	neurological surgery	67.3
	orthopedic surgery	27.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63030	721	1.2	SPONDYLOSIS AND ALLIED DISORDERS
	722	18.5	INTERVERTEBRAL DISC DISORDERS
	724	12.4	OTHER AND UNSPECIFIED DISORDERS O

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63030							
ASGS		090	090	10.97	12.11	1.10	10.88

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
63030								
ASGS	12.11	12.11	0.99	1.11	1.00	1.00	13.90	185

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
63030								
ASGS	090	10.97		33		91		48

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
63030									
ASGS		1.0		10	5.5		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
63030									
ASGS		15		13.90	12.11	xx	n		0.064

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 63042 Global Period: 090 Current RVW: 17.27 Recommended RVW: 16.56

CPT Descriptor: **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, re-exploration; lumbar**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on Key Reference Procedure**
AANS recommended reduced RVW from 17.27 to 16.56.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVW's			Intensity
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	Hrvd3 Wrk/min
63035	LAMINOTOMY, EA ADDTL INTERSPACE								3.15		
63048	LAMINECTOMY/COMPLETE DECOMPR STENOSIS EA ADDTL SEGMENT ANY LEVEL								3.26		
63030	LAMINOTOMY ONE LEVEL FOR HERNIATED DISK UNILATERAL LUMBAR	63	91		125	1080		10.75	12.11		6.31
63030	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK UNILATERAL LUMBAR	70	90		143		1115			11.10 AANS94	5.68 AANS94
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS LUMBAR ONE LEVEL	66	121		114	1282		12.76	12.76	Benchmark Procedure	6.63
63047	LAMINECTOMY/COMPLETE DECOMPR STENOSIS LUMBAR ONE LEVEL	85	120		140		1364			13.57 AANS94	6.22 AANS94
63042	LAMINOTOMY FOR DISK ANY LEVEL EXTENSIVE OR RE-EXPLORATION LUMBAR	66	159		131	1573		15.65	17.27	16.56	6.53
63042	LAMINOTOMY FOR DISK ANY LEVEL EXTENSIVE OR RE-EXPLORATION LUMBAR	83	120		138		1519			15.12 AANS94	7.61

RELATIONSHIP OF 63042 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

These four codes (63030, 63020, 63047 & 63042) are key reference services, with 63047 representing the current benchmark service for the entire set of nervous system codes. Each code was surveyed by the AANS and the time, work and intensity data compiled from the survey allowed calculation of RVWs as noted above in the darker shaded rows labelled AANS94. We have ranked the services in order of their final recommended or existing RVWs indicated in boldface. Comparison of the total work values listed and the intensity factors from Harvard3 or the AANS94 survey also support the proposed rank value order.

A significant difference in the intra-service time for 63042 appeared when the AANS94 survey intra-service time of 120 minutes was compared to the Harvard3 time of 159 minutes. The average time from our operative log database of several hundred patients was 128 minutes, again more than 30 minutes shorter than the earlier Harvard/Hsiao study. The reason for this difference is not clear unless the possible inclusion of multiple level reoperations may have been mixed with single level procedures to extend the intra-service time, since the code does not specify one or many levels. The other time components are reasonably well matched, so the intra-service time is the principal difference between the two sources. One operative log includes 20 cases of 63042 with an intra-service time of 126 minutes, and the same log reports two cases of 63042 + 63048 (EACH ADDITIONAL SEGMENT) with intra-service time of 157 minutes. These times are remarkably close to those in the AANS94 survey of 120 minutes and the Harvard3 time of 159 minutes. (Note that the AANS94 survey vignette specified a patient with a one level lesion.) We suspect that the Harvard3 time data was high due to inclusion of some cases done at more than a single level mixed in with single level cases thereby contributing to a higher intra-service time value.

We suggest that a compromise value between the calculated 15.65 RVW and the current MFS RVW of 17.27 be adopted to accommodate the unmeasured frequency and impact of including and extra 1-2 levels in the procedure, and thence extending the intra-service time and work. A reasonable interim RVW would be 16.56 which splits the difference between the two values. This also is virtually the same as the original MFS92 RVW of 16.67 (see Federal Register, Nov. 25, 1992, p. 55930 for Refinement Panel codes).

SURVEY DATA:

Specialty: Neurological Surgery

63042	Stats	LOS Days	PRE-SERVICE Time			INTRA TIME Time	POST-SERVICE TIME and VISITS									OFFICE VISITS (thru global)		
			Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to Reco very Room	ICU/CCU Visits	Other			Dischg Day Mgmt.	Office Visits			
											No.x	Time	SUM		No.x	Time	SUM	No.x	Time	SUM
min	0	10	10	5	60	5	5	0	0	0	1	8	10	0	1	10	10	
25th%	3	30	15	15	105	10	10	0	0	0	2	10	30	15	2	15	45	
median	3	45	15	25	120	15	15	0	0	0	3	15	45	20	3	15	45	
75th%	4	60	15	30	174	20	20	0	0	0	4	15	60	30	4	20	60	
max	6	180	35	60	240	40	120	1	15	15	7	40	100	60	6	30	120	
intra-time #	102																	
Sample #																		
% response	49%																	

RATIONALE for recommendation:

Work:

Changes in past 5 years

Steady increase in frequency of reoperation for spinal disease with development of spinal surgery programs and clinics

Rank Order (Ordinal) Valuation:

Rank order listed in table appropriate to family of codes

Initial crosswalk or extrapolation misvaluation:

Original Hsiao Phase II total work value of 1811 in 11/90. This was reduced by HCFA in 6/92 to 1571 which was the initial crosswalk value.

Prev. RUC or Refinement Valuation:

MFS92 RVW of 16.67 increased by May 1992 Refinement Panel to 17.69

Time:

Op. Logs:

20 cases; avg. time = 126 min.
2 cases with 63048 for extra level; avg. time = 157 min.

Anesthesia databases:

327 cases; avg. anesth. time = 175 min.

AANS94 Survey Key Refs:

AANS94 survey results above.

Harvard3 Database:

See reference service table above.

Undervalued time/Phase I or II & MFS92:

Original MFS92 RVW was 16.67.

Mental Effort & Judgement:

Significantly higher than for other ref. services.

Technical Skill & Physical Effort:

Higher than all of the ref. services cites due to the difficulty involved in most reoperations in the spinal canal.

Stress:

Higher than the other ref. services due to risks of injury to dura or nerve roots as well as failure to relieve pain.

Intensity/Complexity:

Highest in the family per AANS94 survey data.

Public Comments

30-Jun-95

Code: 63042

1995 RVUs: 17.27

Recommended RVUs: 16.56

Ratio:

Long Descriptor: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, re-exploration; lumbar

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 6,623 **Impact:** -4702

Source: 5 **Year:** 93 **Public Comment Letter:** 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS, AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63042	28	2.5	6	59	20.5	0	0	6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63042	6202	6788	4.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63042	97.2	97.1	0

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63042	neurological surgery	60.2
	orthopedic surgery	35.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63042	721	3.1	SPONDYLOSIS AND ALLIED DISORDERS
	722	14.8	INTERVERTEBRAL DISC DISORDERS
	724	16.1	OTHER AND UNSPECIFIED DISORDERS O
	738	2.3	OTHER ACQUIRED MUSCULOSKELETAL

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63042							
AANS		090	090	15.96	17.27	1.08	15.82

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
63042								
AANS	17.27	17.27	0.99	1.09	1.00	1.00	16.56	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
63042								
AANS	090	15.96		35		159		50

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
63042									
AANS		1.0		10	6.5		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
63042									
AANS		15		16.56	17.27	xx	n		0.066

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 63047 Global Period: 090 Current RVW: 12.76 Recommended RVW: 13.57

CPT Descriptor: **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, re-exploration; lumbar**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS on Key Reference Procedure**
AANS recommended increase RVW from 12.76 to 13.57.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Hrvd3 Wrk/min
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW	
63030	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, LUMBAR	63	91		125	1080		10.75	12.11	*	6.31
63030	LAMINOTOMY, ONE LEVEL FOR HERNIATED DISK, UNILATERAL, LUMBAR	70	90		143		1115			11.10 AANS94	5.68 AANS94
63047	LAMINOTOMY/COMPLETE DECOMPR STENOSIS, LUMBAR, ONE LEVEL	66	121		114	1282		12.76	12.76	Benchmark Procedure	6.63
63047	LAMINOTOMY/COMPLETE DECOMPR STENOSIS, LUMBAR, ONE LEVEL	85	120		140		1364			13.57 AANS94	6.22 AANS94
63042	LAMINOTOMY FOR DISK, ANY LEVEL, EXTENSIVE OR RE-EXPLORATION, LUMBAR	66	159		131	1573		15.65	17.27	16.56	6.53
63042	LAMINOTOMY FOR DISK, ANY LEVEL, EXTENSIVE OR RE-EXPLORATION, LUMBAR	83	120		136		1519			15.12 AANS94	7.61

RELATIONSHIP OF 63047 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:
These four codes (63030, 63020, 63047 & 63042) are key reference services, with 63047 representing the current benchmark service for the entire set of nervous system codes. Each code was surveyed by the AANS and the time, work and intensity data compiled from the survey allowed calculation of RVWs as noted above in the darker shaded rows labelled AANS94. We are concerned that the values for 63047 with a higher calculated total work value than the Harvard3 value of 1282 will require the RVW for the MFS95 to be increased and shift our benchmark procedure value once again (see comments under 63030). However, the concurrence of intra-service time data between Harvard3 and our survey indicates that the principal differences lies in the intensity factor applied to the intra-service time in calculation of work plus some additional pre- and post-service time. Our survey data serves to validate our survey methodology in attempting to replicate the detailed input of time and intensity data into a formula process to derive work values and thence, RVWs that do represent a more accurate relative value scale. A similar observation applies to the survey data and recommended RVW from 62020.

The match between the Harvard3 times and the survey pre-, intra- and post-service times for 63047 indicates that the survey process of measuring each of the components of a total service is consistent between the two models. The survey and calculation of an intra-service intensity factor is also reassuring since the Harvard3 value of 6.63 is quite close to the AANS94 survey intensity value of 6.22. When this factor is multiplied by the total times for the service, the total work values result as noted above. The difference and increase from the Harvard3 total work value and the translated RVW of 12.76 to the AANS94 values and RVW of 13.57 are important. We believe that 63047 should be adjusted to reflect the recommended increase in RVW to 13.57.

The rank order valuation of services as listed in the table above also supports the placement of 63047 at the recommended level. Progressive increases in total work, RVWs and intensity all support this recommendation.

PT Code: 63047

SURVEY DATA:

Specialty: Neurological Surgery

63047	Stats	LOS	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
		Hosp. Stay	Eval. before O.R.	Scrub and Dress	O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT ICU/CCU)	Disch. Day Mgmt.	Office Visits after discharge						
		Days	Time	Time	Time	Time	Time	Time	No.x	Time	SUM	No.x	Time	SUM	Time	No.x	Time	SUM
	min	2	10	10	5	44	5	5	0	0	0	1	8	10	10	1	10	10
	25th%	3	30	15	15	100	10	10	0	0	0	3	10	30	15	2	15	45
	median	3	45	15	25	120	15	15	0	0	0	4	15	45	20	3	15	45
	75th%	4	60	15	30	150	20	24	0	0	0	4	15	75	30	4	20	60
	max	7	180	35	65	240	30	120	2	20	30	8	60	240	60	6	30	120
	Intra-time #	102																
	Sample #																	
	% response	49%																

RATIONALE for recommendation:

Work:

Changes in past 5 years

Steady increase in frequency of reoperation for spinal disease with development of spinal surgery programs and clinics

Rank Order (Ordinal) Valuation:

Rank order listed in table appropriate to family of codes

Initial crosswalk or extrapolation misvaluation:

Initial crosswalk total work = 1282.

Time:

Op. Logs:

14 cases; avg. time = 130 min.

52 cases with 63048 for extra level; avg. time = 166 min.

166 cases; avg. anesth. time = 202 min.

Anesthesia databases:

AANS94 Survey Key Refs:

AANS94 survey results above.

Harvard3 Database:

See reference service table above.

Mental Effort & Judgement:

Intensity intermediate between 63030 and 63042.

Technical Skill & Physical Effort:

Tech. skill approx. same as 63030.

Stress:

Slightly lower than for 63030.

Intensity/Complexity:

Intensity intermediate between 63030 and 63042.

Public Comments

30-Jun-95

Code: 63057

1995 RVUs: 3

Recommended RVUs: 4.20

Ratio:

Long Descriptor: Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment, each additional segment, thoracic or lumbar

Reference Set (y/n): N Global Period: ZZZ Frequency: 135 Impact: 162

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS, AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63057	0	0	0	0	0	0	0	.

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63057	151	152	0.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63057	80.7	90.8	5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63057	general surgery	2.6
	group practices	2.6
	neurological surgery	59.9
	orthopedic surgery	33.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63057	724	12.5	OTHER AND UNSPECIFIED DISORDERS O
	730	12.5	OSTEOMYELITIS, PERIOSTITIS, AND OTH

Public Comments

30-Jun-95

781	12.5	SYMPTOMS INVOLVING NERVOUS AND
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63057							
AANS		ZZZ	ZZZ	5.92	3.00	0.51	3.00

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
63057								
AANS	3.00	3.00	0.51	1.00	1.00	1.00	4.20	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
63057								
AANS	ZZZ	5.92	1					

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
63057									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
63057									
AANS				4.20	3.00		3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 63075 Global Period: 090 Current RVW: 19.77 Recommended RVW: 18.50

CPT Descriptor: **Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace**

Source and Summary of Comment to HCFA on this service:
AANS recommended reduction in RVW from 19.77 to 18.50.

Public Comments by AANS on Key Reference Procedure.
Comments on AAOS recommended value.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
63075	DISKECTOMY, ANTERIOR APPROACH, WITHOUT FUSION, SINGLE, CERVICAL	64	138		115	1362		13.56	19.77	
63075	DISKECTOMY, ANTERIOR APPROACH, WITHOUT FUSION, SINGLE, CERVICAL	80	120		125		1471			18.50 AANS94
63077	DISKECTOMY, ANTERIOR APPROACH, WITHOUT FUSION, SINGLE, THORACIC	79	202		145	2113		21.03	20.25	
63081	VERTEBRAL CORPECTOMY, ANT. DECOMPR. CORD, CERV. SINGLE SEGMENT	76	175		169	2200		21.90	22.08	

RELATIONSHIP OF 63075 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

This is a key reference code and requires comment since our survey reported time data that suggested this procedure has changed since the original MFS92. The Harvard/Hsiao Phase II time for 63075 (DISKECTOMY, ANTERIOR APPROACH, WITHOUT FUSION, SINGLE, CERVICAL) was 138 minutes and a total work value of 1566 was reported. This particular code was used as one of the cross-specialty linkages in 1992 and was matched to 60500 (EXPLORATION FOR PARATHYROID ADENOMA) based on the same intra-service time of 138 minutes. However, 60500 had a Phase II total work value of only 1230. When the two procedures were linked and the scale adjusted to a common scale for all services, the result was a reduction in the RVW for 63075 to 14.42 compared to the the RVW for 60500 at the higher value of 16.23. Without this dislocating linkage adjustment to 63075, the equivalent RVW in the scale of 1995 would have been 15.49.

Further revaluation occurred in the May 1992 refinement process. At that time, the RVW of 14.42 was increased to 20.26 and has subsequently declined to its current value of 19.77 due to the budget neutrality adjustments in the ensuing years.

It appears that the component services in this procedure have changed in the sense that the intra-service times in large series now range from 120 to 157 minutes. This may reflect greater ease in performing the procedure. However it usually includes some additional work that is not accounted for in the current valuation, i.e. use of the operating microscope (61712). In the past several years it has become the usual procedure to use the operating microscope, with increasing attention to a detailed and complete decompression of the anterior spinal canal and foramina through the disk interspace, coupled with frequent resection of the posterior longitudinal ligament to assure complete decompression and removal of all osteophytes and disk fragments. 61712 (MICRODISSECTION WITH THE OPERATING MICROSCOPE) is not an allowed service with 63075 but it is still used in most cases and simply not billed, or not reimbursed if billed. The extra work associated with 61712, which on average adds 31 minutes to the intra-service time, is still provided as part of the service, but the additional RVW of 3.49 are lost.

The nearest comparison codes are 63081 (VERTEBRAL CORPECTOMY, ANTERIOR DECOMPRESSION OF CORD, CERVICAL SINGLE SEGMENT), and 63077 (DISKECTOMY, ANTERIOR APPROACH, SINGLE, THORACIC). Both of these procedures utilize a similar approach to the anterior spine including removal of disk and posterior osteophytes. However, the corpectomy has an average time of 175 minutes compared to the 138 + 31 = 169 minutes for 63075. The present RVWs are 22.08 for 63081 and 19.77 for 63075. We estimate that a RVW of 18.50 would better reflect the relationship of 63075 to other procedures in the family and recommend that this value be considered as a compromise based on the above considerations.

CP: 63075

SURVEY DATA:

Specialty: Neurological Surgery

63075	Stats	LOS	PRE-SERVICE TIME			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)				
			Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Skin Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT ICU/CCU)		Disch Day Mgmt.	Office Visits after discharge		
				Time	Time		Time	Time	Time	No.x		Time	SUM		No.x	Time	SUM
min	0	10	10	9	60	5	5	0	0	0	1	8	10	0	1	10	10
25th%	2	30	15	15	90	10	10	0	0	0	1	10	20	15	2	15	40
median	3	45	15	30	120	15	15	0	0	0	2	15	30	20	3	15	45
75th%	3	60	15	30	137	20	20	0	0	0	3	15	60	30	4	20	60
max	5	150	35	80	200	45	120	1	20	20	7	60	240	60	6	30	180
Intra-time #	102																
Sample #																	
% response	49%																

RATIONALE for recommendation:

Work:

Changes in past 5 years

Change in custom of using operating microscope for 63075 without additional coding of 61712 since it is not an allowed associated code.

Rank Order (Ordinal) Valuation:

Rank order of recommended RVWs in table appropriate as listed.

Initial crosswalk or extrapolation misvaluation:

Initial Hsiao Phase II total work of 1566 in 11/90, reduced by HCFA in 6/91 to 1359. Reduction in initial RVW from 15.49 to 14.42.

Prev. RUC or Refinement Valuation:

May 1992 Refinement increased original RVW of 14.42 to 20.25.

Time:

Op. Logs:

5 cases of 63075 as solo procedure; avg. time = 121 min.

4 cases of 63075 + 61712; avg. time = 151 min.

Anesthesia databases:

1577 cases; avg. anesthesia time = 200 min.

AANS94 Survey Key Refs:

AANS94 surveyed this procedure as above.

Harvard3 Database:

As above.

Undervalued time/Phase I or II & MFS92:

MFS92 RVW was 14.42.

Mental Effort & Judgement:

Technical Skill & Physical Effort:

Less than for either reference code.

Stress:

Intensity/Complexity:

Surveyed intensity 7.20 compared to Harvard3 of 6.43.

Public Comments

30-Jun-95

Code: 63075

1995 RVUs: 19.77

Recommended RVUs: 18.50

Ratio:

Long Descriptor: Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctectomy; cervical, single interspace

Reference Set (y/n): Y Global Period: 090 Frequency: 7,099 Impact: -9016

Source: 5 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AANS, AAOS

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63075	17.1	0.3	12.6	43.3	32.1	0	2.6	7.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63075	6223	7859	12.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63075	98.1	96.9	-0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63075	anesthesiology	2.5
	neurological surgery	80.4
	orthopedic surgery	12.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63075	721	8.3	SPONDYLOSIS AND ALLIED DISORDERS
	722	15.9	INTERVERTEBRAL DISC DISORDERS
	723	7	OTHER DISORDERS OF CERVICAL REGIO

Public Comments

30-Jun-95

724	1	OTHER AND UNSPECIFIED DISORDERS O
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Harvard Data:

Comm	Modif	Packlv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63075							
AANS		090	090	13.84	19.77	1.43	13.69

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
63075								
AANS	19.77	19.77	0.99	1.44	1.00	1.00	18.50	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
63075								
AANS	090	13.84		32		138		58

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdviedur	Hvis	Svdhvis	Hviedur	Icuvis	Offvis
63075									
AANS		1.0		10	5.0		10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
63075									
AANS		15		18.50	19.77	xx	n		0.065

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
SUMMARY OF RECOMMENDATION
Comments on Misvalued Code**

CPT Code: 63087 Global Period: 090 Current RVW: 27.56 Recommended RVW: 33.91

CPT Descriptor: Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment

Source and Summary of Comment to HCFA on this service:
AANS recommended increase in the RVW of 27.56 to 33.91.

Public Comments by AANS and AAOS.
Current AANS95 survey.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62 year old woman with a history of CA of the breast has had 5 weeks of back pain with increasing weakness of the proximal leg muscles, patchy perineal numbness, and some incontinence. The X-rays show a lytic lesion in L1 and an MRI exam shows diffuse involvement of L1 body with enhancing tumor which extends into the lumbar spinal canal anteriorly, compressing the conus. An anterior approach to the T12-L1 area is made and the body of L1 entered and all accessible tumor removed. Tumor extending into the ventral epidural space is also removed.

Description of Pre-Service Work: includes review of previous medical records regarding the breast tumor and it's therapy, evaluation the imaging studies, and appropriate lab and screening studies. Pre-service work includes informed consent with the patient and family plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup. Positioning is more complex due to the use of a decubitus position and need to enter both the retroperitoneal area as well as the lower chest.

Description of Intra-Service Work: The position is a modified decubitus to allow access to the thoraco-lumbar junction. This usually requires release of the diaphragm and a rib resection to reach the T12-L1 level. When the vertebral surface is exposed, the regional nutrient vessels are identified, tested for safety of division, and subsequently sectioned and ligated. The body of L1 is identified and entered after removal of the overlying great vessels and muscular attachments. Tumor in the bone is removed along with both end plates and the two adjacent disks. Tumor extending into the ventral epidural space is removed to bare dura. When the corpectomy is completed, some type of arthrodesis and stabilization are required but are not included in the scope of this specific procedure code. In closing, the diaphragm requires reattachment, a chest tube is placed, and the muscle and fascial layers are closed. The skin layer is also closed, and dressings applied.

Description of Post-Service Work: includes patient stabilization, communication with the family and referring physician (including written and telephone reports and orders), removal of a drain, if used, and monitoring for signs of bleeding or neurologic deterioration. All hospital visits, ICU visits, and discharge day management are included. Discharge records are prepared and post-discharge office visits for wound and general care are completed during the 90 day global period.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Intensity Hr/d5 Intra Wrk/min
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hr/d3	AANS	Hr/d3 to MFS95	MFS95	Rec.New RVW	
63081	VERTEBRAL CORPECTOMY ANT DECOMPR CORD CERV SINGLE SEGMENT	76	175		169	2200		21.90	22.08		7.30
63085	VERTEBRAL CORPECTOMY,ANT,DECOMPR CORD ROOTS THOR SINGLE SEGM LEVEL	87	233		192	2661		26.49	25.07		7.84
63090	VERTEBRALCORPECTOMY,RETROPERITONEA L / DECOMP.CORD ROOTS T OR L SINGLE	83	232		189	2635		26.23	26.20		7.84
63087	VERTEBRAL CORPECTOMY,T-L APPR./DECOMP.CORD,ROOTS SINGLE SEG	86	258		189	2771		27.58	27.56	14.43 AAOS	7.33
63087	VERTEBRAL CORPECTOMY,T-L APPR./DECOMP.CORD,ROOTS SINGLE SEG.	105	265	30	180		3408			33.91 AANS95	8.91 AANS94

RELATIONSHIP OF 63087 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:
 The Harvard3 time and total work data for 63087 (VERTEBRAL CORPECTOMY, T-L APPR/DECOMP. CORD. ROOTS SINGLE SEG.) and the other reference codes in this family appear to have face validity as well as an ascending scale of values that reflect the progressive increase in work. The present MFS95 RVWs also reflect a reasonable translation of the Harvard3 total work to the MFS95. The reduced value of 14.43 for 63087 suggested by the AAOS is completely out of relative order to the reference codes.

63090 (VERTEBRAL CORPECTOMY, RETROPERITONEAL/DECOMP. CORD. ROOTS, T OR L, SINGLE) is an alternate approach to the same target. It involves a flank exposure with reflection of the peritoneum and contents to the opposite side in order to expose the anterior and lateral aspect of the lumbar spine. When applied to the L1 or T12-L1 level, it then becomes 63087, since it requires the additional services described below. 63090 has a total work value and RVW that are in general rank order with 63087.

The closest comparison as a reference service is 63085 (VERTEBRAL CORPECTOMY, ANT DECOMPR. CORD. ROOTS, THOR. SINGLE SEGM. LEVEL) with comparable time and work values. However, there is a critical difference in that 63087 involves more labor in exposure of the vertebral surfaces at the thoracic-lumbar junction since it requires a detachment of the diaphragm in order to expose the target. This also increases the stress and the overall intensity. The intensity factors as listed from Harvard3 for the intra-service work are all relatively close, except for a reduction to 7.33 for 63087 to the same level as 63081 (VERTEBRAL CORPECTOMY, ANT DECOMPR. CORD. CERV SINGLE SEGMENT), which is a substantially less complex and intense service. These additional work factors support an increase in the RVW for 63087. Our AANS95 Survey of 63087 shows a higher total work value of 3408, which converts to the current scale of RVWs to 33.91.

SURVEY DATA:

Specialty: Neurological Surgery

63087	Stats	RVW	LOS Days	PRE-SERVICE Time			INTRA TIME	POST-SERVICE TIME and VISITS						OFFICE VISITS (thru global)					
				Hosp. Stay	Eval. before O.R.	Scrub and Dress		O.R. Entry to Skin Open	Skin Open to Close	Skin Close to O.R. Exit	Recovery Room	ICU/CCU Visits	Other Hospital Visits (NOT ICU/CCU)	Disc h Day Mgmt	Office Visits after discharge				
															No.x	Time	SUM	No.x	Time
min	19.11	5	15	15	15	90	15	0	0	0	0	3	5	15	10	1	5	5	
25th%	25.39	7	41	15	25	210	20	15	1	15	15	5	10	50	20	3	15	45	
median	26.20	8	50	15	30	255	25	20	2	15	30	6	15	90	20	3	15	45	
75th%	27.28	10	83	15	44	300	30	30	3	20	60	9	15	131	30	4	20	80	
max	32.00	15	120	40	60	480	60	120	6	40	240	12	25	300	45	10	30	300	
survey n	275																		
RVW resp	40																		
rate %	15%																		

RATIONALE for recommendation:

Work:
 Rank Order (Ordinal) Valuation: Basis for validating current RVWs.
 Initial crosswalk or extrapolation misvaluation: Increase in 6/91 total work from 2585 to 3/92 work of 2771.
 Prev. RUC or Refinement Valuation: 5/92 RVW of 27.44 increased to 28.24.

Time:
 AANS95 Survey: See table above.
 Harvard3 Database: Harvard3 data appears reasonable to support RVW values.

Mental Effort & Judgement: Slightly greater for 63087.
Technical Skill & Physical Effort: Greater skill and effort due to difficult approach.
Stress: Stress and risk higher with both chest, abdomen and diaphragm open.
Intensity/Complexity: Higher complexity due to entrance into chest + take down of diaphragm for exposure of spine.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 63655 Global Period: 090 Current RVW: 8.95 Recommended RVW: 9.30

CPT Descriptor: **Laminectomy for implantation of neurostimulator electrodes; epidural**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS and AAPM.**
AANS recommended increase in RVW from 8.95 to 9.30.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVW's		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
63685	INCISION & SUB-Q PLACEMENT NEUROSTIMULATOR OR PULSE GENERATOR	53	62		72	616		6.13	6.29	
63744	REPLACEMENT, IRRIGATION OR REVISION LUMBOSUBARACHNOID SHUNT	56	75		93	737		7.34	6.83	7.34
63741	CREATION OF SHUNT, LUMBAR NOT REQ LAMINECTOMY	59	86		86	761		7.57	7.13	7.57
63750	INSERTION OF LUMBAR SUBARACH CATHETER WITH RESERVOIR	59	88		96	785		7.81	7.23	7.81
63655	LAMINECTOMY/IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, EPIDURAL	62	109		112	934		9.30	8.95	9.30
63740	CREATE SHUNT, LUMBAR, SUBARACH-PERITONEAL, PLEURAL OR OTHER	64	116		115	1042		10.37	10.43	10.37

RELATIONSHIP OF 63655 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

These procedures are related in both content and type/intensity of work, but are listed in a rank order progression that is supported by the table of comparative times and work from the Harvard3 database as listed above.

The reference procedure for this set is 63685 (INCISION AND SUBQ PLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER..) which has a RVW of 6.29 which appears appropriate. The rank order of the procedures that follow 63685 are arranged to reflect their total work and relative values appropriately. The RVW's from the Harvard3 data are converted to the scale of the 1995 MFS for reference. We recommend an increase in the RVW to 9.30 for 63655. This will also assure that the laminectomy that is done as a part of this service is included in the total work value.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation: The listed rank order progression of time, total work and translated RVW's are appropriate.

Initial crosswalk or extrapolation misvaluation: Initial total work of 888 increased to 934

Prev. RUC or Refinement Valuation:

Time:

Harvard3 Database: The increase above the MFS95 RVW, compared to the reference service 63685, is based on substantial increases in the intra- and post-service time and work. The Harvard3 data appear appropriate to the services listed above.

Mental Effort & Judgement:

Technical Skill & Physical Effort:

Stress:

Intensity/Complexity:

Public Comments

30-Jun-95

Code: 63655

1995 RVUs: 8.95

Recommended RVUs: 9.30

Ratio:

Long Descriptor: Laminectomy for implantation of neurostimulator electrodes; epidural

Reference Set (y/n): N Global Period: 090 Frequency: 312 Impact: 109

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey:

Societies Wishing to Comment: AANS, AAPM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63655	15.4	0	15.4	76.9	23.1	0	15.4	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63655	495	314	-20.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63655	94.7	90.8	-2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63655	anesthesiology	2.9
	group practices	3.5
	neurological surgery	72.9
	neurology	3.8
	orthopedic surgery	16.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63655	355	3.6	MONONEURITIS OF LOWER LIMB AND U
	585	3.6	CHRONIC RENAL FAILURE

Public Comments

30-Jun-95

724	7.1	OTHER AND UNSPECIFIED DISORDERS O
953	3.6	INJURY TO NERVE ROOTS AND SPINAL P
996	3.6	COMPLICATIONS PECULIAR TO CERTAI

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63655							
AANS		090	090	9.48	8.95	0.94	8.95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
63655								
AANS	8.95	8.95	0.94	1.00	1.00	1.00	9.30	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
63655								
AANS	090	9.48		30	*	109		44

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
63655									
AANS	*	1.0	*	10	5.0	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
63655									
AANS	*	15		9.30	8.95	ns	3		0.044

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 63740 Global Period: 090 Current RVW: 10.43 Recommended RVW: 10.37

CPT Descriptor: **Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other, including laminectomy**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended decrease in RVW from 10.43 to 10.37.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVW's		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
63685	INCISION & SUB-Q PLACEMENT NEUROSTIMULATOR OR PULSE GENERATOR	53	62		72	616		6.13	6.29	
63744	REPLACEMENT, IRRIGATION OR REVISION LUMBOSUBARACHNOID SHUNT	56	75		93	737		7.34	6.83	7.34
63741	CREATION OF SHUNT, LUMBAR NOT REQ LAMINECTOMY	59	86		86	761		7.57	7.13	7.57
63750	INSERTION OF LUMBAR SUBARACH CATHETER WITH RESERVOIR	59	88		96	785		7.81	7.23	7.81
63655	LAMINECTOMY/IMPLANTATION OF NEUROSTIMULATOR ELECTRODES EPIDURAL	62	109		112	934		9.30	8.95	9.3
63740	CREATE SHUNT, LUMBAR, SUBARACH-PERITONEAL, PLEURAL OR OTHER	64	116		115	1042		10.37	10.43	10.37

RELATIONSHIP OF 63740 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

These procedures are related in both content and type/intensity of work, but are listed in a rank order progression that is supported by the table of comparative times and work from the Harvard3 database as listed above.

The reference procedure for this set is 63685 (INCISION AND SUBQ PLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER ..) which has a RVW of 6.29 which appears appropriate. The rank order of the procedures that follow 63685 are arranged to reflect their total work and relative values appropriately. The RVW's from the Harvard3 data are converted to the scale of the 1995 MFS for reference. We recommend a decrease in the RVW to 10.37 for 63740.

RATIONALE for recommendation:

Work:
 Rank Order (Ordinal) Valuation: The listed rank order progression of time, total work and translated RVW's are appropriate.
 Initial crosswalk or extrapolation misvaluation: Initial total work of 948 to 1042 in March 1992.
 Prev. RUC or Refinement Valuation: 3/92 RVW of 10.06 to 10.69 in 5/92 refinement panel.

Time:
 Harvard3 Database: The increase above the MFS95 RVW, compared to the reference service 63685, is based on substantial increases in the intra- and post-service time and work. The Harvard3 data appear appropriate to the services listed above.

Mental Effort & Judgement:
Technical Skill & Physical Effort:
Stress:
Intensity/Complexity:

Public Comments

30-Jun-95

Code: 63740

1995 RVUs: 10.43

Recommended RVUs: 10.37

Ratio:

Long Descriptor: Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other, including laminectomy

Reference Set (y/n): N Global Period: 090 Frequency: 224 Impact: -13

Source: 5 Year: 93 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey:

Societies Wishing to Comment: AANS

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63740	50	25	50	50	0	25	0	0

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
63740	295	276	-3.3

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63740	96.6	99.3	1.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
63740	general surgery	2.2
	group practices	2.5
	neurological surgery	92.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63740	331	18.8	OTHER CEREBRAL DEGENERATIONS
	348	6.3	OTHER CONDITIONS OF BRAIN

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63740							
AANS		090	090	10.58	10.43	0.99	9.54

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
63740								
AANS	10.43	10.43	0.90	1.09	1.00	1.00	10.37	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notatw	Pret	Svdpre	ftime	Notett	Imppt
63740								
AANS	090	10.58		31	*	116		46

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
63740									
AANS	*	1.0	*	10	5.0	*	10	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
63740									
AANS	*	15		10.37	10.43	ns	3		0.049

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 63741 Global Period: 090 Current RVW: 7.13 Recommended RVW: 7.57

CPT Descriptor: **Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; percutaneous, not requiring laminectomy**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 7.13 to 7.57.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVW's		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
63685	INCISION & SUB-Q PLACEMENT NEUROSTIMULATOR OR PULSE GENERATOR	53	62		72	616		6.13	6.29	
63744	REPLACEMENT, IRRIGATION OR REVISION LUMBOSUBARACHNOID SHUNT	56	75		93	737		7.34	6.83	7.34
63741	CREATION OF SHUNT, LUMBAR, NOT REQ LAMINECTOMY	59	86		86	761		7.57	7.13	7.57
63750	INSERTION OF LUMBAR SUBARACH CATHETER WITH RESERVOIR	59	88		96	785		7.81	7.23	7.81
63655	LAMINECTOMY/IMPLANTATION OF NEUROSTIMULATOR ELECTRODES EPIDURAL	62	109		112	934		9.30	8.95	9.3
63740	CREATE SHUNT, LUMBAR, SUBARACH-PERITONEAL, -PLEURAL OR OTHER	64	116		115	1042		10.37	10.43	10.37

RELATIONSHIP OF 63741 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

These procedures are related in both content and type/intensity of work, but are listed in a rank order progression that is supported by the table of comparative times and work from the Harvard3 database as listed above.

The reference procedure for this set is 63685 (INCISION AND SUBQ PLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER ..) which has a RVW of 6.29 which appears appropriate. The rank order of the procedures that follow 63685 are arranged to reflect their total work and relative values appropriately. The RVW's from the Harvard3 data are converted to the scale of the 1995 MFS for reference. We recommend an increase in the RVW to 7.57 for 63741.

RATIONALE for recommendation:

Work:

Rank Order (Ordinal) Valuation: The listed rank order progression of time, total work and translated RVW's are appropriate.

Initial crosswalk or extrapolation misvaluation: Initial total work of 708 to 761 in March 1992.

Prev. RUC or Refinement Valuation:

Time:

Harvard3 Database: The increase above the MFS95 RVW, compared to the reference service 63685, is based on substantial increases in the intra- and post-service time and work. The Harvard3 data appear appropriate to the services listed above.

Undervalued time/Phase I or II & MFS92:

Technical Effort & Judgement:

Technical Skill & Physical Effort:

Stress:

Intensity/Complexity:

Public Comments

30-Jun-95

Code: 63741

1995 RVUs: 7.13

Recommended RVUs: 7.57

Ratio:

Long Descriptor: Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other, percutaneous, not requiring laminectomy

Reference Set (y/n): N Global Period: 090 Frequency: 276 Impact: 121

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

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Societies Wishing to Survey:

Societies Wishing to Comment: AANS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63741	50	0	0	50	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63741	166	332	41.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63741	97.6	68.1	-14.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63741	anesthesiology	48.2
	neurological surgery	45.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63741	331	12.5	OTHER CEREBRAL DEGENERATIONS
	388	4.2	OTHER DISORDERS OF EAR
	722	4.2	INTERVERTEBRAL DISC DISORDERS
	724	12.5	OTHER AND UNSPECIFIED DISORDERS O

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63741							
AANS		090	090	7.72	7.13	0.92	7.13

Harvard Data:

Comm	Mawk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
63741								
AANS	7.13	7.13	0.92	1.00	1.00	1.00	7.57	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
63741								
AANS	090	7.72						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
63741									
AANS									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
63741									
AANS				7.57	7.13	ns	3		

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 63744 Global Period: 090 Current RVW: 6.83 Recommended RVW: 7.34

CPT Descriptor: **Replacement, irrigation or revision of lumbosubarachnoid shunt**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS.**
AANS recommended increase in RVW from 6.83 to 7.34.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVW's		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
63685	INCISION & SUB-Q PLACEMENT NEUROSTIMULATOR OR PULSE GENERATOR	53	62		72	616		6.13	6.29	
63744	REPLACEMENT, IRRIGATION OR REVISION LUMBOSUBARACHNOID SHUNT	56	75		93	737		7.34	6.83	7.34
63741	CREATION OF SHUNT, LUMBAR NOT REQ LAMINECTOMY	59	86		86	761		7.57	7.13	7.57
63750	INSERTION OF LUMBAR SUBARACH CATHETER WITH RESERVOIR	59	88		96	785		7.81	7.23	7.81
63655	LAMINECTOMY/IMPLANTATION OF NEUROSTIMULATOR ELECTRODES EPIDURAL	62	109		112	934		9.30	8.95	9.3
63740	CREATE SHUNT, LUMBAR, SUBARACH-PERITONEAL, PLEURAL OR OTHER	64	116		115	1042		10.37	10.43	10.37

RELATIONSHIP OF 63744 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

These procedures are related in both content and type/intensity of work, but are listed in a rank order progression that is supported by the table of comparative times and work from the Harvard3 database as listed above.

The reference procedure for this set is 63685 (INCISION AND SUBQ PLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER ..) which has a RVW of 6.29 which appears appropriate. The rank order of the procedures that follow 63685 are arranged to reflect their total work and relative values appropriately. The RVW's from the Harvard3 data are converted to the scale of the 1995 MFS for reference. We recommend an increase in the RVW to 7.34 for 63744.

RATIONALE for recommendation:

Work:
 Rank Order (Ordinal) Valuation: The listed rank order progression of time, total work and translated RVW's are appropriate.
 Initial crosswalk or extrapolation misvaluation: Initial work value of 678 to 737.

Time:
 Harvard3 Database: The increase above the MFS95 RVW, compared to the reference service 63685, is based on substantial increases in the intra- and post-service time and work. The Harvard3 data appear appropriate to the services listed above.

Mental Effort & Judgement:
 Technical Skill & Physical Effort:
 Stress:
 Intensity/Complexity:

Public Comments

30-Jun-95

Code: 63744

1995 RVUs: 6.83

Recommended RVUs: 7.34

Ratio:

Long Descriptor: Replacement, irrigation or revision of lumbosubarachnoid shunt

Reference Set (y/n): N Global Period: 090 Frequency: 128 Impact: 65

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey:

Societies Wishing to Comment: AANS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63744	0	0	0	0	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63744	117	150	13.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63744	82.9	76.7	-3.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63744	anesthesiology	18
	general surgery	2
	neurological surgery	73.3
	radiology	6.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63744	996	25	COMPLICATIONS PECULIAR TO CERTAI

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Peckhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63744							
AANS		090	090	7.49	6.83	0.91	6.83

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
63744								
AANS	6.83	6.83	0.91	1.00	1.00	1.00	7.34	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ftime	Notett	Imppt
63744								
AANS	090	7.49		26		75		39

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
63744									
AANS		1.0	*	10	4.0		10	0.0	1.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
63744									
AANS		15		7.34	6.83	ns	3		0.047

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW**

Comments on Misvalued Code

CPT Code: 63750 Global Period: 090 Current RVW: 7.23 Recommended RVW: 7.81

CPT Descriptor: **Insertion, subarachnoid catheter with reservoir and/or pump for intermittent or continuous infusion of drug, including laminectomy**

Source and Summary of Comment to HCFA on this service: **Public Comments by AANS and AAPM.
AANS recommended increase in RVW from 7.23 to 7.81.**

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs		
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec.New RVW
63685	INCISION & SUB-Q PLACEMENT NEUROSTIMULATOR OR PULSE GENERATOR	53	62		72	616		6.13	6.29	
63744	REPLACEMENT, IRRIGATION OR REVISION LUMBOSUBARACHNOID SHUNT	56	75		93	737		7.34	6.83	7.34
63741	CREATION OF SHUNT, LUMBAR, NOT REQ LAMINECTOMY	59	86		86	761		7.57	7.13	7.57
63750	INSERTION OF LUMBAR SUBARACH CATHETER WITH RESERVOIR	59	88		96	785		7.81	7.23	7.81
63655	LAMINECTOMY/AMPLANTATION OF NEUROSTIMULATOR ELECTRODES, EPIDURAL	62	109		112	934		9.30	8.95	9.3
63740	CREATE SHUNT, LUMBAR, SUBARACH-PERITONEAL, PLEURAL OR OTHER	64	116		115	1042		10.37	10.43	10.37

RELATIONSHIP OF 63750 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

These procedures are related in both content and type/intensity of work, but are listed in a rank order progression that is supported by the table of comparative times and work from the Harvard3 database as listed above.

The reference procedure for this set is 63685 (INCISION AND SUBQ PLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER ..) which has a RVW of 6.29 which appears appropriate. The rank order of the procedures that follow 63685 are arranged to reflect their total work and relative values appropriately. The RVWs from the Harvard3 data are converted to the scale of the 1995 MFS for reference. We recommend an increase in the RVW to 7.81 for 63750.

RATIONALE for recommendation:

Work:
 Rank Order (Ordinal) Valuation: The listed rank order progression of time, total work and translated RVWs are appropriate.
 Initial crosswalk or extrapolation misvaluation: Initial work value of 718 increased to 785.

Time:
 Harvard3 Database: The increase above the MFS95 RVW, compared to the reference service 63685, is based on substantial increases in the intra- and post-service time and work. The Harvard3 data appear appropriate to the services listed above.

Mental Effort & Judgement:
Technical Skill & Physical Effort:
Stress:
Intensity/Complexity:

Public Comments

30-Jun-95

Code: 63750

1995 RVUs: 7.23

Recommended RVUs: 7.81

Ratio:

Long Descriptor: Insertion, subarachnoid catheter with reservoir and/or pump for intermittent or continuous infusion of drug, including laminectomy

Reference Set (y/n): Y Global Period: 090 Frequency: 317 Impact: 184

Source: 1 Year: 92 Public Comment Letter: 340

Reference Services:

CMD Comment:

Societies Wishing to Survey:

Societies Wishing to Comment: AANS, AAPM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
63750	50	0	0	40	40	0	0	40

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
63750	407	363	-5.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
63750	69.3	93.9	12.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
63750	anesthesiology	21.8
	neurological surgery	62.8
	orthopedic surgery	8.3
	thoracic surgery	3.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
63750	161	2.5	MALIGNANT NEOPLASM OF LARYNX
	162	2.5	MALIGNANT NEOPLASM OF TRACHEA, B

Public Comments

30-Jun-95

195	2.5	MALIGNANT NEOPLASM OF OTHER AND
200	2.5	LYMPHOSARCOMA AND RETICULOSARC
722	5	INTERVERTEBRAL DISC DISORDERS
724	5	OTHER AND UNSPECIFIED DISORDERS O
780	5	GENERAL SYMPTOMS
952	5	SPINAL CORD INJURY WITHOUT EVIDEN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
63750							
AANS		090	090	7.97	7.23	0.91	7.23

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
63750								
AANS	7.23	7.23	0.91	1.00	1.00	1.00	7.81	340

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
750								
AANS	090	7.97		28	*	88		42

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
63750									
AANS	*	1.0	*	10	3.5	*	10	0.0	2.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
63750									
AANS	*	15		7.81	7.23	ns	3		0.044

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW
CMD Comments
Comments on Misvalued Code**

CPT Code: 64443 Global Period: ZZZ Current RVW: 1.35 Recommended RVW: 0.98

CPT Descriptor: **Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, each additional level**

Source and Summary of Comment to HCFA on this service: **CMD Comments and Public Comments by AANS.**
 CMD recommended reduced RVW from 1.35 to 0.70. AANS recommends a decrease RVW from 1.35 to 0.98.

REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Time in minutes				Work		RVWs			Global
		Pre-Svc	Intra-Svc	ICU	Post-Svc	Hrvd3	AANS	Hrvd3 to MFS95	MFS95	Rec. New RVW	
62274	INJECTION OF ANESTHETIC, DIAGNOSTIC OR THERAPEUTIC SUBARACH SPINAL	13	16		9	176		1.75	1.78		000
64440	INJECTION, ANESTHETIC AGENT, PARAVERTEBRAL NERVE (THOR LUMB SACRAL) SINGLE VERT LEVEL	15	26		27	181		1.80	1.34		000
64442	INJECTION, ANESTHETIC AGENT, PARAVERTEBRAL FACET JOINT NERVE LUMBAR SINGLE LEVEL	8	18		20	180		1.79	1.41		000
64441	INJECTION, ANESTHETIC AGENT, PARAVERTEBRAL NERVES MULTIPLE LEVELS (REGIONAL BLOCK)	16	44		28	230		2.28	1.79		000
64443	INJECTION, ANESTHETIC AGENT, PARAVERTEBRAL FACET JOINT NERVE LUMBAR EA ADDTL LEVEL	8	27		20	204		2.03	1.35	0.98	ZZZ
64443	INJECTION, ANESTHETIC AGENT, PARAVERTEBRAL FACET JOINT NERVE LUMBAR EA ADDTL LEVEL	8	27		20	204		2.03	1.35	0.70 CMD95	ZZZ

RELATIONSHIP OF 64443 TO KEY REFERENCE SERVICES and Other Rationale for RVW Recommendation:

The CMD comments identified 64442 (INJECTION, ANESTHETIC AGENT; PARAVERTEBRAL FACET JOINT, LUMBAR, SINGLE LEVEL) as the reference service for this code. This is an appropriate choice since 64443 represents the same service at each additional level. The key difference cited by the CMD in recommending a reduction of 50% in the RVW is the different global period for the two codes; 64442 has a 000 global period while 64443 has a ZZZ global which means it falls under the global period of the parent procedure, ie, 64442. The general rule for a ZZZ is that it will have only 50% of the work value of the primary procedure, since that is a crude average of the ratio between intra-service work and total work for many major procedures. Unfortunately, with many minor procedures, that ratio does not hold true. For these two codes, the ratio is approximately 61%. Also consider that these global periods have been changed since the MFS92 when they were all 010, with only a 25% reduction in RVWs when changed to a 000 global period. 64443 was reduced 33% in the same period, probably reflecting the change to a ZZZ global. To impose an additional 50% reduction at this time is not appropriate, since the only overlap that may still remain in the present RVW is represented by the 20 minutes of post-service time listed for 64443, which would not be allowed under the ZZZ rules. If the work of that post-service period is subtracted from the total work of 64443, the resulting work will be 147 which translates to a RVW of 0.98. It appears reasonable to recommend that a RVW of 0.98 be adopted rather than the double reduction that the CMD recommendation contained.

CMD Comments

30-Jun-95

Code: 64443

1995 RVUs: 1.35

Recommended RVUs: 0.70

Ratio: -0.48

Long Descriptor: Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, each additional level

Reference Set (y/n): N Global Period: ZZZ Frequency: 48,861 Impact: -31759.65

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
64443			
	64442 INJECTION FOR NERVE BLOCK	1.41	000

CMD Comment:

Should differ from 64442 by the lack of pre and post- service work. Recommended value is 50% of the value of 64442

Societies Wishing to Survey: AAOS

Societies Wishing to Comment: AANS, AAPM, AAPMR, ACEP, ASIM

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
64443	43.1	8.5	11.8	62.3	23.9	0.2	0.1	10.8

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
64443	25958	50350	39.3

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
64443	7	4.7	-1.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
64443	anesthesiology	53.9
	general family practice	5.4
	internal medicine	3
	neurological surgery	10.5
	orthopedic surgery	9.6
	radiology	5.9
	rehabilitation medicine	6.2

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

ICD9	Pct of Time Used	ICD9 Descriptor
64443		
715	2.5	OSTEOARTHRISIS AND ALLIED DISORD
721	3.5	SPONDYLOSIS AND ALLIED DISORDERS
722	4.8	INTERVERTEBRAL DISC DISORDERS
723	1.7	OTHER DISORDERS OF CERVICAL REGIO
724	19.8	OTHER AND UNSPECIFIED DISORDERS O
729	1.6	OTHER DISORDERS OF SOFT TISSUES
739	1.2	NONALLOPATHIC LESIONS, NOT ELSEW

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfawk95	Ratio5h	Mfawk92
64443							
CMD		010	ZZZ	2.07	1.35	0.65	1.63

Harvard Data:

Comm	Mawk93	Mfawk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
64443								
CMD	1.63	1.35	0.79	1.00	0.83	1.00	0.70	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
64443								
CMD	ZZZ	2.07		8		27		8

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
64443									
CMD		0.0		0	0.0		0	0.0	1.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfawk95	Sp	Phase	Twput	Iwput
64443									
CMD		10		0.70	1.35	ns	3		0.049

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Ophthalmology

The specialty society is responding to recommendations by the Carrier Medical Directors that the RVUs for 11 cataract related codes should be reduced. In addition, the society has surveyed several codes and recommended increases in their work RVUs. Arguments for changes in RVUs were supported by surveys, comparisons to cross specialty codes and other rationale for why the procedure has changed and now requires adjusted work RVUs. The response rates and resulting samples were of sufficient size to validate the study.

Generally the RUC found the data, comparisons and arguments convincing. The threshold for the RUC was to show compelling evidence that the procedure changed, the patient population changed, or that the code had been originally undervalued or overvalued. When the RUC recommended a different RVU, it typically attempted to rectify new survey data and rationale with Harvard data, producing final recommended RVU increases below those recommended by the specialty society. In all; 7 codes were reduced in value, 12 codes were increased in value, and for 29 codes the RUC recommended to retain the current value.

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*Key (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3= Adopt specialty/CMD recommended decrease; 4= Adopt increased RVU, but lower than specialty recommended; 5= Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
65101	Removal of eye	6.52	6.52	Code 65101 should be increased to 12.75.	No compelling evidence was presented to change the code. The specialty society provided no further evidence to support this comment. The RUC recommends that this code maintain its current value.	2
65205	Remove foreign body from eye	0.78	0.71	CMD: Reduce RVU to 0.55; The total work for this service which has a global period of zero should be no more than 15 minutes office visit (code 99213, RVU = 0.55).	The specialty society argued that the work intensity is greater than 65220, <i>Remove foreign body from eye</i> , because the foreign body can be more difficult to find in 65205. Survey RVU came out to .80 and intra-service time was 5 min. The RUC was not convinced that the intensity was greater than 65220. The RUC recommends that the RVU be set equal to 65220.	5
65430	Corneal smear	0.87	1.47	Code 65430 should be increased. It requires greater time and cognitive intensity than 68761, <i>Close tear duct opening</i> , at 1.31.	Survey data show median intra-service time of 10 min. and a median RVU of 1.51. Similar to <i>biopsy of the eye</i> . A comparison to 65410, <i>biopsy of cornea</i> , would be more appropriate. The RUC recommends that the RVU be set equal to 65410.	4

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
65450	Treatment of corneal lesion	3.07	3.07	A clinic recommended increasing the RVU to be compatible with 67208, <i>destruction localized lesion of retina</i> , with a value of 6.40.	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends that the current RVUs be maintained.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
65710	Corneal transplant	9.52	11.75	These codes are undervalued. They are the most stressful of all eye operations. The patient is awake under local anesthesia and a large hole is cut into the eye. The procedures are open and are at risk for hemorrhagic expulsion of the inner eye contents, forever blinding the eye. The corneal transplant also requires substantial pre-service clinical data.	65710 and 65730 were surveyed. Intra-service time of 90 min. for both and median RVUs of 12.00 and 13.50 were greater than current values. The technology has changed because the use of corneal topography has caused intensity and post-service work to increase. Much of this is due to increased expectations on the part of patients for a better outcome. The corneal topography is not billed as a separate service. Survey data and rationale for increased pre and post-service time increases are compelling. The increased precision offered by the corneal topography would add to the intensity of the procedure. The RUC recommends that the RVU be increased, but that the same ratio between the services be maintained.	1
65730	Corneal transplant	11.83	13.50			1
65750	Corneal transplant	12.58	14.25			4
65755	Corneal transplant	12.58	14.25			4
65820	Relieve inner eye pressure	7.60	7.60	Code 65820 should be increased. The code was never directly studied by Harvard; the values were derived.	Procedure is only performed on children. Survey data show median intra-service time of 60 min. and a median RVU of 8.00. Intensity has increased. The recommended increase in RVU is not significant. The current value should be maintained.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
65855	Laser surgery of eye	4.65	4.15	CMD: Reduce to 4.15; Once the treatment series is completed, there are few follow up visits following 65855 unless there is uveitis or another complication. The procedure itself involves less time and intensity than 65865, <i>Incise inner eye adhesions</i> . In total work, it is closer to 65860, <i>Incise inner eye adhesions</i> , than 65865.	The survey data show a median intra-service time of 15 min. and a median RVU of 4.65. The society believed that the CMDs comparison was not valid. Service is more similar to 66761, <i>Revision of iris</i> . The RUC agreed with the CMDs and believed that the work has changed. Current use of drugs lessens the anxiety and need for speed. This has served to reduce the intensity.	3
66170	Implant eye shunt	11.31	11.26	Code 66180 is undervalued relative to 67107, <i>Repair of retinal detachment</i> , at 13.99 and 66172, <i>Implant eye shunt</i> , at 13.67.	The specialty society comment was withdrawn. A rank order anomaly exists among the codes. 66180 is the most complex and least used. Appropriate increases and reductions were made based on the frequency with which the procedures are performed. The RVU changes should be work neutral. The rank order problem is apparent. The RUC recommends that the RVUs be changed as suggested by the specialty society.	3 Add
66172	Implant eye shunt	13.67	13.62			3 Add
66180	Implant eye shunt	12.63	14.00			1

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
66821	After cataract laser surgery	2.78	2.78	CMD: Reduce to 2.30; The technical skill and work intensity for 66821 are significantly lower than 66820, <i>Incision secondary cataract</i> . Intra-service time is about half. Outpatient visits are fewer.	The survey data show median intra-service time of 11 min. and a median RVU of 3.42. Intra-service skill and complexity is the same as 66761, <i>revision of iris</i> , and 67031, <i>laser surgery eye strands</i> . Less time and complexity than 66820, <i>Incision secondary cataract</i> . The survey data and comparisons are compelling. The procedure is similar to 66820, <i>Incision secondary cataract</i> . The RUC recommends that the current values be maintained.	2
66825	Reposition intraocular lens	7.73	7.73	Code 66825 is undervalued relative to 66984, <i>Remove cataract, insert lens</i> , at 9.89 RVUs.	Survey data show median intra-service time of 60 min. and a median RVU of 9.50. Code is a combination of 65920, <i>remove implant from eye</i> , and 66985, <i>insert lens prosthesis</i> . The RUC reviewed this code in 1992 and HCFA accepted the recommendation of the RUC at that time. HCFAs agreement for 8.15 RVUs appeared in the Federal Register for November 25, 1992. The RUC recommends that the current values be maintained.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
66830	Removal of lens lesion	7.80	7.80	<p>CMD: Harvard Phase III data indicate 54 minutes of intra-service time for 66984. This number appears excessive in light of current practice. With current technology, 66984 is not a highly stressful procedure. 44950, <i>Appendectomy</i>, at 6.13, average procedure time exceeds 66984--may be more difficult. Still carries considerable morbidity and mortality. The rest of the codes in this family are reduced in proportion to 66984.</p> <p>Several clinics and specialty societies wrote letters during the public comment period stating their belief that code 66984 is undervalued.</p>	<p>The society surveyed 66984. Survey data show median intra-service time of 50 min. which compares to the established survey time of 54 min. The survey median RVU was 11.00 which compares to the established RVU of 9.89. The comparison to 44950, <i>appendectomy</i>, is erroneous. This procedure has an intra-service time of 37 min. and a work RVU of 6.06. The time and work involved are clearly different from 66984. Based on the survey data and the faulty comparison to 44950, the current value should be maintained for 66984. Since the CMDs based their reduction of all these codes on the reduction of 66984, the RUC recommends that all these codes maintain their current value.</p>	2
66840	Removal of lens material	7.51	7.51			
66850	Removal of lens material	8.66	8.66			
66852	Removal of lens material	9.52	9.52			
66920	Extraction of lens	8.46	8.46			
66930	Extraction of lens	9.73	9.73			
66940	Extraction of lens	8.48	8.48			
66983	Remove cataract, insert lens	8.54	8.54			
66984	Remove cataract, insert lens	9.89	9.89			
66985	Insert lens prosthesis	7.89	7.89			
66986	Exchange lens prosthesis	11.78	11.78			
67005	Partial Removal of eye fluid	6.63	5.50	<p>CMD: Reduce to 5.50 RVUs; CPT code 67005 is overvalued compared to reference CPT code 67010 which is a more thorough and technically involved procedure than 67005.</p>	<p>The RUC recommends that the CMD recommendation for a reduction be accepted.</p>	3

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
67015	Release of eye fluid	6.69	6.69	CMD: Increase to 7.50; This procedure is performed under emergency circumstances and has a great deal of associated morbidity. Intensity is greater than 67010 and time is slightly greater.	No compelling reason to increase the RVUs. Societies provided no evidence to support this recommendation. The RUC recommends that the current value be maintained.	2
67312	Revise two eye muscles	7.55	8.19	The intra-service work for 67312 is twice that for 67311. If two muscles in one eye undergo surgery, essentially all the intra-service tasks must be performed twice.	67311, <i>Revise eye muscle</i> , is a single muscle operation. It is valued at 6.3 RVUs. According to second procedure rule 67312 should be valued at 50% of 67311. Since it is really only the intra-service time that is doubled, 50% of the intra-service time of 67311 will be added to 67312. The intra-service time accounts for 60% of the RVU. The RUC recommends that the values be increased.	4
67316	Revise two eye muscles	8.02	9.26			4
67420	Orbitotomy with bone flap or window	13.36	19.00	Code 67420 is undervalued. The work involved exceeds that of epiretinal membrane stripping which is valued at 20.69 RVUs, and 61333, Explore orbit, remove lesion, at 26.75.	Survey data show median intra-service time of 180 min. and a median RVU of 20.00. Compare to 21267, <i>orbital repositioning</i> , which is less time, skill and stress. 67420 is under valued relative to other codes in the family. The survey and rationale are compelling. Tumor removal is more difficult. Rank order needs to be corrected. The RUC recommends that the RVU be increased.	1

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
67900	Repair brow defect	4.54	5.84	CMD: Raise RVU to 5.84; This procedure is essentially the beginning of a craniotomy. Furthermore, this procedure carries with it the risk of 7th cranial nerve damage, hair loss and significant infection.	Survey data show median intra-service time of 70 min. and a median RVU of 7.90. The RUC recommends that the CMDs rationale and recommendation for an increase be accepted.	1
67904	Repair eyelid defect	5.96	5.96	Code 67904 should have a greater work value than 14040, Skin tissue rearrangement, which has 7.18 RVUs.	Survey data show median intra-service time of 60 min. and a median RVU of 9.00. One code has been extracted from a family of codes. An increase would affect the rank order.	2
67911	Revise eyelid defect.	5.09	5.09	Society commented that code should have a greater RVU than 26121, Release palm contracture, at 7.34.	No compelling evidence to increase the RVU. The RUC recommends that the current value be maintained.	2
67924	Repair eyelid defect	5.64	5.64	Society commented that the code requires more work and should have a higher RVU than 14040, <i>skin tissue rearrangement</i> .	No compelling evidence to increase RVU. The RUC recommends that the current value be maintained.	2
67966	Excision and repair of eyelid	6.39	6.39	This code requires more work and should have a greater work value than 14040, <i>skin tissue rearrangement</i> , valued at 7.18 RVUs.	Recommendation for increase has been withdrawn. The RUC recommends that the current value be maintained.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
68720	Create tear sac drain	7.68	8.56	The closest reference code is 31205, <i>Removal of ethmoid sinus</i> , with 9.65 RVUs. However, in 68720 special steps are taken in addition to excision in order to give the best chance of a post-surgical patent fistula. These are part of the procedure and reveal how 68720 is undervalued.	Survey data show median intra-service time of 90 min. and a median RVU of 11.17. Compare to 21385, <i>open repair orbital for fix</i> , at 8.56 RVUs and 21275, <i>secondary revision of orbitofacial</i> , at 10.50 RVUs. The RVU for 68720 is under valued in comparison. Survey data and comparisons are compelling. The RUC recommends that the RVU be increased to equal 21385, <i>open repair orbital for fix</i> .	4
68745	Create tear duct drain	8.23	8.23	The RVUs of 68745 and 68750 are reversed. 68750 is more difficult than 86745. The RVUs of both should be increased and the ratio among the codes changed to reflect the difference in work.	No compelling reason to increase the RVUs. The rank order of these two codes is currently correct. The RUC recommends that the current values be maintained.	2
68750	Create tear duct drain	8.21	8.21			2
68830	Re-open tear duct channel	2.12	2.12	The RVU should be similar to 30115, <i>Removal of nose polyp(s)</i> , at 4.25. Both codes involve intranasal surgery.	No compelling reason to increase the RVU. The society provided no further evidence to support the comment. The RUC recommends that the current value be maintained.	2

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*Key (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3= Adopt specialty/CMD recommended decrease; 4= Adopt increased RVU, but lower than specialty recommended; 5= Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
92018	New eye exam & treatment	1.51	1.51	CMD: Reduce to .88 and .38; This is usually done for evaluation of a child. The ophthalmologist may need to bring additional equipment, but this procedure is no more difficult and the risk is no greater than 57400, <i>dilation of vagina under anesthesia</i> , 57410, <i>pelvic examination under anesthesia</i> , and is certainly not the same as 99215 (the most difficult return office visit patient).	92018 was surveyed. Survey data show median intra-service time of 30 min. and a median RVU of 2.50. Comparisons made by the CMDs are incorrect in terms of type of service delivered and time of service. Survey results and rationale are compelling. Use of general anesthesia increases risk of procedure. However, no compelling reason to increase RVU. The RUC recommends that the current value be maintained.	2
92019	Eye exam & treatment	1.31	1.31			2
92020	Special eye evaluation	0.37	0.37	CMD: Reduce RVU to .16; CPT describes this as a separate procedure, but Medicare allows this to be billed with an eye exam. This is a unilateral exam compared to 92081 which is a bilateral exam. The interpretation is not as difficult as 71020, <i>chest X-ray</i> .	Two surveys were done by different societies. Survey data show median RVUs of .55 and .60. The code is similar to 99213, <i>Office visit</i> , which has an RVU of 0.55. Comparison to 71020 is flawed. 92020 is a much more dynamic procedure. The RUC recommends that the current value be maintained.	2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
92060	Special eye evaluation	0.50	0.69	CMD: Reduce RVU to 0.23; This is no different than what a neurologist does for the examination of any parietic muscle. CPT definition is that this is a separate procedure and Medicare pays for it along with any other exam.	Survey data show median intra-service time of 30 min. and a median RVU of 1.40. The nature and scope of this service is greater than indicated by the CMDs. Survey data was compelling in that it showed intra-service times in excess of the original data. The RUC recommends that the RVU be returned to the Harvard value.	4
92070	Fitting of contact lens	0.70	0.70	This code should be increased to 1.05 RVUs. It is undervalued when compared to the reference code 99202, <i>office visit new patient</i> , and 99214, <i>office visit established patient</i> .	No compelling evidence to increase the RVU. The society provided no evidence to support the comment. The RUC recommends that the current value be maintained.	2
92275	Electroretinography	1.01	1.01	CMD: Reduce RVU to 0.40; This test is very similar to visual evoked response except that the recording instrument is placed on the cornea.	Survey data show median intra-service time of 45 min. and a median RVU of 1.47. Work involved is very different from VER. The RUC recommends that the current value be maintained.	2
92283	Color vision examination	0.26	0.17	CMD: Reduce to 0.17; This is almost always done by non-physicians. The physician work involved is less than the interpretation of an electrocardiogram or chest X-ray.	The RUC recommends that the CMD recommendation for a reduction be accepted.	3

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*Key (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3= Adopt specialty/CMD recommended decrease; 4= Adopt increased RVU, but lower than specialty recommended; 5= Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comments	RUC Rationale	Key *
92284	Dark adaptation eye exam	0.37	0.24	CMD: Reduce to 0.24; This is almost always done by non-physicians. The physician work involved is less than the interpretation of an electrocardiogram or chest X-ray.	The RUC recommends that the CMD recommendation for a reduction be accepted.	3

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*Key (1= Adopt specialty/CMD recommended increase; 2= Maintain current RVU; 3= Adopt specialty/CMD recommended decrease; 4= Adopt increased RVU, but lower than specialty recommended; 5= Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 66984 Global Period: 090 Current RVW: 9.89 Recommended RVW: 9.89
(Maintain current values for related procedures: 66830, 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66985, 66986 -- 7.73, 7.80, 7.51, 8.66, 9.52, 8.46, 9.73, 8.48, 8.54, 7.89, 11.78)

CPT Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

Source and Summary of Comment to HCFA on this service:

CMD Comments:

Recommended RVUs: 7.90

Reference Codes: 44950, 65235

Rationale for Change: Harvard Phase III data indicate 54 minutes of intra-service time. This number appears excessive in light of current technology, this is not a highly stressful procedure.

Appendectomy at 6.13, average procedure time exceeds 66984 -- may be more difficult. Still carries considerable morbidity and mortality.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used by American Academy of Ophthalmology in Survey: "70 year old female complains of vision problems. Examination reveals that a cataract in her right eye has matured to the point of visual impairment. She has difficulty reading and recently failed a driving test. Cataract surgery is performed and an intraocular lens is implanted. Recovery is monitored and the patient is examined through regularly scheduled postoperative visits."

Vignette Used by American Optometric Association in Survey of Post Operative Care: "A 68 year old male returns one week after successful cataract surgery on the right eye with implantation of a posterior IOL, for continuing post surgical care."

Description of Pre-Service Work: Preparation of the patient begins in the surgical holding area. It is the ophthalmic surgeon's responsibility to ascertain the correct eye to be operated upon. The eye is briefly examined to rule out any substantive changes since the last examination. The adequacy of pupillary dilation is checked. Preoperative topical antibiotics may be administered to the operative eye. The patient is greeted and any final questions or concerns are addressed. The surgeon checks pertinent aspects of the patient's chart and notes vital signs, laboratory, radiologic and electrocardiographic data. If not previously performed, an appropriate history and physical is performed. The ophthalmic surgeon may then perform a peribulbar or retrobulbar anesthetic block. This may be performed while short-acting intravenous neuroleptic anesthesia is given. The patient's vital signs are closely monitored to guard against respiratory arrest or other such potential emergency. The surgeon may then elect to place an ocular compressive device on the eye to reduce intraorbital pressure. This may remain in place for several minutes during which time the patient's vital signs are monitored.

Description of Intra-Service Work: Once the patient is transported to the surgical suite, it is the surgeon's responsibility to position the patient properly for intraocular microsurgery. This will vary by patient based on the patient's physiognomy. The surgeon then performs or supervises the prepping and draping of the operative site. The adequacy of the anesthetic block must be checked. If a peribulbar or retrobulbar anesthetic block is not used, the application of topical or subconjunctival anesthetic is carried out. The surgeon then performs a proper surgical scrub and gowns. Automated cataract extraction devices such as phacoemulsification units must be checked to assure that the proper irrigation, aspiration and phacoemulsification parameters are entered. The surgeon must check that the machine operates properly. The microscope then is positioned to assure an adequate light reflex. Communication with the anesthesiologist or anesthesiologist is necessary to assure the patient's intraoperative physical stability. The surgeon then places a lid speculum and possibly a bridle-suture(s) to assure proper position of the eye. A flap of conjunctiva might be raised to lend access to the surgical limbus. Hemostasis is accomplished with a proper cautery instrument. A precise side-port incision is made away from the surgical incision. The manner of surgical incision varies: It may be a "clear-corneal" incision performed with a diamond keratome; a surgical limbus incision; or a "scleral-tunnel" incision which requires a partial thickness scleral incision with forward tunneling into clear cornea with a crescent knife. In the case of the latter incision, the actual configuration of the incision may be arcuate, tangential or parallel to the limbus. A viscoelastic substance is usually employed to insufflate the anterior chamber. The anterior chamber is then entered with a sharp blade to a precise incision size of 3.2 millimeters. A sharp bent needle or cystotome is used to fashion an opening in the anterior capsule of the cataract. This is done in a circular fashion to ensure strength and integrity. Its diameter routinely measures 5 to 8 millimeters. The cataractous lens is then loosened by injecting fluid between the lens and its capsule, a process known as hydrodissection. The surgeon may also choose to inject fluid between the lamella of the lens material itself, a process known as hydrodelamination. Additional viscoelastic material may then be injected into the anterior chamber prior to phacoemulsification. The function of the phacoemulsification handpiece is checked again. If satisfactory, the tip is inserted into the eye. Careful and precise phacofragmentation with simultaneous aspiration of the lens material is carried out. The lens must be rotated and is commonly "disassembled" to avoid inadvertent trauma to intraocular structures. It is common to employ a two-handed technique to accomplish this disassembly. The side-port incision is used to allow access to a second instrument used in the non-dominant hand. The dense cataractous material is thus removed from the eye. The phacoemulsification tip is removed from the eye. An irrigation-aspiration tip is introduced into the eye to commence cleanup of the residual cortical lens material. The thin, transparent lens capsule is then carefully vacuumed and polished in an attempt to avoid future secondary membrane formation. At this point, the anterior segment is ready to receive the intraocular lens. Depending on the lens style deemed appropriate by the surgeon, the incision may need to be opened to a larger chord-length. Many different methods are used to deliver intraocular lenses. It is critical to assure proper positioning and centration of the intraocular lens. It is generally agreed that this is best accomplished by ensuring that the prosthesis is precisely located in the empty lenticular capsule. The integrity of this fragile, transparent membrane is of paramount importance. Some surgeons elect to create a peripheral iridectomy in the iris. The surgeon must now evacuate the viscoelastic substance from the eye to prevent post-operative complication. This is generally accomplished with the irrigation and aspiration handpiece.

CPT Code: 66984

The anterior chamber must be properly pressurized and the incisional site must be assessed for the need of sutures to guarantee a water-tight closure. A miotic solution may then be injected into the eye to produce pupillary miosis. If a conjunctival flap was prepared, it must be securely fastened at its point of insertion. The bridle suture(s) and lid speculum are removed. It is common to inject an antibiotic and steroid in the subtenons space. An antibiotic ointment may be placed on the eye. A soft patch and a rigid shield is then positioned on the operative eye by the surgeon. The patient is then prepared to leave the operative suite.

Description of Post-Service Work: This work usually begins immediately after the surgery. The surgeon will commonly speak with the patient and the patient's family. Instructions are given and explained, questions are addressed and a prognosis is given. It is the surgeon's responsibility to ascertain the patient's ability to leave the surgical facility. The patient is seen the next day in the ophthalmic office. All follow-up examinations include a history of the postoperative course, an examination of the operative eye including vision, intraocular pressure, and ophthalmic evaluation of the anterior and posterior segment, and further instructions are given for medication use, patient activity and future follow-up. Corneal keratometry and topography are commonly performed post-operatively to ascertain surgical stigmatism. The global surgical period for CPT code 66984 is 90 days. It is common to see the patient up to six times in that time period. A post-operative spectacle examination is carried out usually between weeks three and six and a spectacle prescription is dispensed if the refraction is stable. If complications occur, these add to the time and intensity of the postoperative work.

CPT Code: 66984

SURVEY DATA:

Specialty: American Academy of Ophthalmology

Sample Size: 103 Response Rate (%): 32 Median RVW: 11.00

25th Percentile RVW: 10.00 75th Percentile RVW: 12.00 Low: 7.5 High: 15.78

Median Pre-Service Time: 44 Median Intra-Service Time: 50

25th Percentile Intra-Svc Time: 31.25 75th Percentile Intra-Svc Time: 60 Low: 10 High: 120

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	<u> </u>
ICU	<u> </u>	<u> </u>
Other Hospital:	<u> </u>	<u> </u>
Office:	<u>65</u>	<u>4</u>

SURVEY DATA: 66984-55 (split global care modifier)

Specialty: American Optometric Association

Sample Size: 70 Response Rate (%): 47 Median RVW: 2.75

25th Percentile RVW: 2.00 75th Percentile RVW: 4.00 Low: 1.47 High: 8.33

Median Pre-Service Time: N/A Median Intra-Service Time: N/A

25th Percentile Intra-Svc Time: N/A 75th Percentile Intra-Svc Time: N/A Low: N/A High: N/A

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u> </u>	<u> </u>
ICU	<u> </u>	<u> </u>
Other Hospital:	<u> </u>	<u> </u>
Office:	<u>60</u>	<u>4</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	44950	Appendectomy	6.06
2)	65235	Remove foreign body from eye	7.12

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

44950

The Carrier Medical Director suggested that appendectomy (44950) has an average procedure time which exceeds cataract surgery (66984) and may be a more difficult procedure. The comparison is erroneous

- o First, there is evidence that appendectomy is undervalued. The ACS is recommending an increase for appendectomy from 6.13 to 9.09 and the ASGS is recommending an increase to 8.22.
- o Intra-service time for cataract surgery is still higher. Harvard data indicates that the intra-service time for cataract surgery has fallen from 54 minutes to 50.
- o Cataract surgery still requires more post-operative care. Harvard data indicates that there are 45 minutes of post-operative work in appendectomies (2.5 10 minute hospital visits and 2 additional 10 minute office visits). Cataract surgery requires more follow-up work. The Harvard data indicates that there were 82.5 follow-up minutes (5.5 15 minute visits). The AAO's survey indicates that there are 4 visits and 68 follow-up minutes. Optometrists (using a vignette which describes only the follow-up care more than one week after surgery) reported 4 visits and 92 minutes. AHCPR's cataract guidelines recommend 4 post-operative visits and a larger survey conducted by Johns Hopkins indicates that 88% of patients had 4 or more follow-up visits within a 4 month period.
- o Appendectomies are performed by 1st year residents and 4th year medical students. Cataract surgeries are generally not performed until the second year of ophthalmic residency.

66985

Most respondents (17) identified 66985 as a reference procedure. That procedure has 7.89 RVUs. Our survey data indicates the intra-service time for 66985 is 30 minutes and all other time data for the two procedures is virtually identical. Intra-service time for 66984 is 50 minutes. Code 66985 has an average intensity level of 3.48 which is lower than cataract surgery's 3.95. We believe that the current RVU differential of 2.00 RVUs is appropriate given the additional time and intensity of 66984.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The current intra-service time for cataract is now slightly less than when it was first surveyed by Harvard because of the increased use of phacoemulsification in the last five years. Today about 60% of cataract extractions employ phacoemulsification while only 5-10% of surgeries involved phaco when 66984 was first studied. Both procedure are billed as 66984.

Extracapsular surgery requires a large incision which necessitates more intra-service time to close. However, it is technically easier and safer than operating through the small incision used in phacoemulsification. Most respondents (19 to 31) agreed that the work has changed but only 2 said that the work is now easier. They rated the technical difficulty to be 4.17. This newer technique is more stressful, technically difficult, and fraught with greater iatrogenic risk. This reflected in the increasing numbers of cataract nuclei which are lost into the vitreous cavity intra-operatively with phacoemulsification. The second leading cause of malpractice claims related to cataract extraction is now due to these iatrogenic complications. The greater skill in phacoemulsification is the delay in residents performing cataract surgery from their first year when using extracapsular technique to the second or third years for phacoemulsification in most training programs.

The nature of the pre-service work has changed in the last five years. Patients not only expect to see better post-operatively but to see better without glasses. This requires more pre-service planning of the wound construction and location to decrease the patient's underlying astigmatism. This often requires that the surgeon to operate in a more awkward position. The post-service has also changed because of the reporting demands of managed care and the need to maintain an on-going program of outcomes assessment.

Despite the marketing claims of some high volume cataract surgeons, the average intra-service time has declined little since the Harvard study (see Table 1). The RUC is directed to study and evaluate the work in the average patient, with average pathology, by the average surgeon in the routine setting - not the work of the occasional high volume surgeon operating in dedicated facilities. The AAO feels that the slight decrease in intra-service time is offset by the greater intensity, skill and iatrogenic risk and that the current value of 66984 should be maintained. It should be noted that the RUC has not decreased the RVW of procedures which have less intra-service time because of the use of smaller incision e.g. open cholecystectomy.

Cataract surgery still involves more intra-operative and total time than appendectomies. Median intra-operative time has fallen from 54 to 50 minutes for cataract surgery and are 37 times for appendectomy. The median total amount of time required is now about 183 minutes (45 pre + 50 + intra + 20 post, 5 same day post + 68 office). Appendectomies require 163 minutes (31 pre + 27 intra + 40 post, 10 same day post + 45 hospital and office visits).

The Carrier Medical Directors comments erroneously compared cataract surgery with appendectomies. Cataract surgery is more difficult to perform and takes more time. In rating the amount of work involved in a procedure, the RUC generally focuses on physician work and stress, not (as the CMD did) the risk to patients. The recommended reductions should be rejected and the current value maintained.

TABLE 1: CATARACT SURGERY: INTRA-SERVICE TIME DATA

MINUTES

54	Harvard Intra Service Time
50	AAO RUC Survey
52	University of Virginia ASC Operating Room Logs: Procedure Time for 8 ophthalmologists and 299 cataract surgeries
41	Barnes Hospital, St. Louis Missouri, Median of the median surgical times of 14 ophthalmologists (average of medians is 40)
44	ABT Associates Study of Anesthesiology Work Relative Values Phase 1: Median procedure time for 00142/66984 (Anesthesia for procedures on eye; lens surgery)
51	ABT Associates Study of Anesthesiology Work Relative Values Phase 2 Median intra service time for code 00142 (survey results)
71	Federal Register, Vol. 58, No. 235, Thursday, December 8, 1994, DHHS, Health Care Financing Administration, <u>Medicare Program: Physician Fee Schedule for Calendar Year 1995; Payment Policies and Relative Value Unit Adjustment. Final Rule.</u> pg. 63456. "For example, cataract anesthesia (CPT code 00142) has a uniform base value of 4 units and an average time unit of 4.74 units." A time unit is 15 minutes therefore average total anesthesia time is 71 minutes (4.74 x 15).
41	Data from Fairfax Hospital, Fairfax, Virginia, 422 procedures
60	Data from Cooper Hospital/University Medical Center, 81 procedures
64	Data from University of Missouri-Columbia, 251 procedures

CMD Comments

30-Jun-95

Code: 66984

1995 RVUs: 9.89

Recommended RVUs: 7.90

Ratio: -0.20

Long Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

Reference Set (y/n): Y **Global Period:** 090 **Frequency:** 1,323,569 **Impact:** -2633902.31

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
66984			
44950	APPENDECTOMY	6.06	090
65235	REMOVE FOREIGN BODY FROM EYE	7.12	090

CMD Comment:

Harvard Phase III data indicate 54 minutes of intra- service time. This number appears excessive in light of current practice. With current technology, this is not a highly stressful procedure. Appendectomy at 6.13, average procedure time exceeds 66984—may be more difficult. Still carries considerable morbidity and mortality.

Societies Wishing to Survey: AAO

Societies Wishing to Comment: AOA-HCPAC, CLAO

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
66984	60.6	13.8	9	65.2	2.1	0.2	0.6	14.1

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
66984	1477440	1902294	13.5

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
66984	1.8	1.1	-0.4

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
66984		
	ophthalmology	75.2
	other nonphysician prov	23.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
66984			
	366	25.3	CATARACT

CMD Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packdv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
66984							
ASCat&RS		090	090	10.34	9.89	0.96	9.89
Clinic		090	090	10.34	9.89	0.96	9.89
CMD		090	090	10.34	9.89	0.96	9.89
IND		090	090	10.34	9.89	0.96	9.89

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
66984								
ASCat&RS	9.89	9.89	0.96	1.00	1.00	1.00	10.00	286
Clinic	9.89	9.89	0.96	1.00	1.00	1.00	23.70	45
CMD	9.89	9.89	0.96	1.00	1.00	1.00	7.90	
IND	9.89	9.89	0.96	1.00	1.00	1.00	11.53	418

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
66984								
ASCat&RS	090	10.34		25		54		34
Clinic	090	10.34		25		54		34
CMD	090	10.34		25		54		34
IND	090	10.34		25		54		34

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
66984									
ASCat&RS		0.5		10	0.0		0	0.0	5.5
Clinic		0.5		10	0.0		0	0.0	5.5
CMD		0.5		10	0.0		0	0.0	5.5
IND		0.5		10	0.0		0	0.0	5.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
66984									
ASCat&RS		15		10.00	9.89	xx	n		0.121
Clinic		15		23.70	9.89	xx	n		0.121

CMD Comments

30-Jun-95

CMD	15	7.90	9.89	xx	n	0.121
IND	15	11.53	9.89	xx	n	0.121

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 65205 Global Period: 000 Current RVW: 0.78 Recommended RVW: 0.71

CPT Descriptor: Removal of foreign body, external eye; conjunctival superficial

Source and Summary of Comment to HCFA on this service:

CMD Comment:

Recommended RVUs: 0.55

Reference Codes: 65220

Rationale for Change: The total work for this service which has a global period of zero should be no more than 15 minutes office visit (code 99213, RVU= 0.55)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "28 year old carpenter enters complaining of sudden onset of tearing, light sensitivity and pain in the right eye. Upon eversion of the upper lid, a small wood fragment is found."

Description of Pre-Service Work: The chart is reviewed. The emergency room chart is reviewed.

Description of Intra-Service Work: A past ocular and general medical history is taken. An external exam, evaluation of distant vision and slit lamp with fluorescein is performed. This shows multiple superior abrasions in the cornea. The cornea is anesthetized, the lid is everted, and the foreign body is removed with forceps. The eye is patched over antibiotics for 24 hours. The patient is counseled for the delayed sequelae of recurrent corneal erosion and infection.

Description of Post-Service Work: Communication with the family and any referring physicians is performed.

SURVEY DATA:Specialty: American Academy of OphthalmologySample Size: 103 Response Rate (%): 26 Median RVW: 0.8025th Percentile RVW: 0.60 75th Percentile RVW: 1.00 Low: 0.20 High: 3.00Median Pre-Service Time: 5 Median Intra-Service Time: 525th Percentile Intra-Svc Time: 5 75th Percentile Intra-Svc Time: 10 Low: 2 High: 20

Median Post-Service Time:

	<u>Number of Visits</u>	<u>Total Time</u>
Day of Procedure:	<u>5</u>	<u> </u>
ICU:	<u> </u>	<u> </u>
Other Hospital:	<u> </u>	<u> </u>
Office:	<u> </u>	<u>n/a</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	65205	Remove foreign body from eye	0.78
2)	65220	Remove foreign body from eye	0.71
3)	99213	Office/outpatient visit, est.	0.55

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The preservice and post service of 65220 and the key reference codes 99213 and 65220 are basically the same. The time of the service is the same as 99213 but 65205 includes the manipulation and removal of the foreign body in addition to the history taking and counseling normally provided with 99213. The time involved, the technical skill and iatrogenic risk are almost identical to 65220. However, the work involved in locating and removing the foreign body is greater than in 65220 because the foreign body is not as visible or as accessible as in 65205. For these reasons we feel that the current RVU of .78 for 65205 is appropriate.

We concur with the RUC's Multi-disciplinary Workgroup 6 that an RVW of .71 (same as 65220) is reasonable.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

See above (Relationship of Code Being Reviewed to Key Reference Services).

CMD Comments

30-Jun-95

Code: 65205

1995 RVUs: 0.78

Recommended RVUs: 0.55

Ratio: -0.29

Long Descriptor: Removal of foreign body, external eye; conjunctival superficial

Reference Set (y/n): N Global Period: 000 Frequency: 12,285 Impact: -2825.55

Source: 17 Year: 93 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
65205			
	65220 REMOVE FOREIGN BODY FROM EYE	0.71	000

CMD Comment:

The total work for this service which has a global period of zero should be no more than 15 minutes office visit (code 99213, RVU = 0.55)

Societies Wishing to Survey: AAP

Societies Wishing to Comment: AAO, ACEP, AOA-HCPAC, CLAO

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
65205	48.6	10.5	7.3	47.1	8.3	0	0	20.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
65205	12990	12536	-1.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
65205	0.6	0.2	-0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
65205		
	emergency medicine	5.8
	general/family practice	15.7
	group practices	2.7
	internal medicine	3.2
	ophthalmology	60.4
	other nonphysician prov	10.8

Claims-Level Diagnosis Information:

CMD Comments

30-Jun-95

ICD9	Pct of Time Used	ICD9 Descriptor
65205		
365	1.1	GLAUCOMA
366	1.8	CATARACT
372	2.3	DISORDERS OF CONJUNCTIVA
379	1.4	OTHER DISORDERS OF EYE
918	2.1	SUPERFICIAL INJURY OF EYE AND ADNE
930	20.2	FOREIGN BODY ON EXTERNAL EYE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
65205							
CMD		010	000	0.57	0.78	1.37	0.78

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
65205								
CMD	0.78	0.78	1.37	1.00	1.00	1.00	0.55	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
65205								
CMD	000	0.57		5		7		5

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
65205									
CMD		0.0		0	0.0		0	0.0	0.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
65205									
CMD		10		0.55	0.78	op	3		0.060

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 65430 Global Period: 000 Current RVW: 0.87 Recommended RVW: 1.47

CPT Descriptor: Scraping of cornea, diagnostic, for smear and/or culture

Source and Summary of Comment to HCFA on this service:

The AAO recommended an increase in the value of this procedure.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A forty-five year old, soft contact lens wearing gardener complains of pain, redness and photophobia and rapid loss of vision in his left eye for the past three days. He felt a foreign body sensation in his eye then noted a white spot in his cornea. He has a past history of cold sores on his lips. Examination reveals a 2 mm diameter corneal ulcer which has eroded through half the corneal thickness and no foreign body."

Description of Pre-Service Work: After ophthalmologist performs a comprehensive history and physical examination, particular attention is paid to the conjunctiva, and measurements and drawings of the corneal ulcer. Corneal sensation and lacrimal function are assessed. Contact lenses and cases are inspected and cultured.

Description of Intra-Service Work: After application of topical anesthetic, an eyelid speculum is inserted. Observing with a slit lamp biomicroscope, a sterile platinum spatula is used to repeatedly scrape the edges of the corneal ulcer. Scrapings are smeared onto glass slides which are treated with gram, giemsa and fungal stains. Additional scrapings are inoculated onto a variety of microbiological cultures to detect aerobic and anaerobic bacteria, fungi and in special cases culture media for herpes virus and protozoa. The stained smears are promptly examined, usually by the ophthalmologist, with light microscopy to determine the type of cellular response and to search for infectious agents. The need for immediate evaluation and interpretation of smear is necessitated by the avascular nature of the cornea and its inability to fight infection like tissue. The cultures are promptly incubated.

Description of Post-Service Work: Based on the interpretation of the smears, anti-infectives are selected and treatment started.

SURVEY DATA:Specialty: American Academy of OphthalmologySample Size: 103 Response Rate (%): 34 Median RVW: 1.5125th Percentile RVW: 1.03 75th Percentile RVW: 2.48 Low: 0.50 High: 11.50Median Pre-Service Time: 10 Median Intra-Service Time: 1025th Percentile Intra-Svc Time: 7 75th Percentile Intra-Svc Time: 15 Low: 5 High: 55

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u> </u>	<u>8</u>
	<u> </u>	

ICU: Other Hospital: Office: **KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	65205	Removal of foreign body	0.78
2)	65410	Biopsy of cornea	1.47

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The code being reviewed is more complex and time consuming than the reference code. (65205 - which according to Harvard data takes 17 minutes and our recent study says it takes 15 minutes). Scraping of the cornea (65430) requires debridement of infected tissue for diagnostic purposes and takes 28 minutes. The infected tissue is then cultured on a variety of microbiologic media and microscopic glass slides for subsequent staining and microscopic examination. Care must be taken in doing the scraping of the normally clear cornea to minimize the damage from the procedure and to obtain the best material for culture which are considerations. Removal of conjunctival foreign body has no such concerns.

We concur with the work group that this procedure is very similar to a biopsy of the cornea (CPT code 65410) and an RVW of 1.47 is reasonable.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Scraping of the cornea is like taking a small biopsy of the eye for diagnostic purposes. A titanium spatula is used to scrape the bed and edges of the corneal ulcer to remove infected corneal tissue for microbiological and cytological study. Multiple scrapings are done to obtain sufficient material for each type of study.

Public Comments

30-Jun-95

Code: 65430

1995 RVUs: 0.87

Recommended RVUs: Inc

Ratio:

Long Descriptor: Scraping of cornea, diagnostic, for smear and/or culture

Reference Set (y/n): N

Global Period: 000

Frequency: 4,046

Impact:

Source: 2

Year: 92

Public Comment Letter: 459

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO, AAP

Societies Wishing to Comment: AOA-HCPAC

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
65430	44.9	16.8	15.8	54.2	9.3	0	1.9	14.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
65430	4404	4510	1.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
65430	5.7	4.1	-0.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
65430	ophthalmology	96.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
65430	362	1.9	OTHER RETINAL DISORDERS
	366	1.4	CATARACT
	370	14.5	KERATTITIS
	371	3.5	CORNEAL OPACITY AND OTHER DISORD
	372	4.2	DISORDERS OF CONJUNCTIVA
	379	2.8	OTHER DISORDERS OF EYE

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfewk92
65430							
AAOph		000	000	1.15	0.87	0.76	0.87

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
65430								
AAOph	0.87	0.87	0.76	1.00	1.00	1.00	INCR	459

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
65430								
AAOph	000	1.15		12		14		12

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
65430									
AAOph		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
65430									
AAOph		0		INCR	0.87	op	3		0.045

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 65710 Global Period: 090 Current RVW: 9.52 Recommended RVW: 11.75

CPT Descriptor: Keratoplasty (corneal transplant); lamellar

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A fifty-five year old man complains that his contact lens keeps falling out resulting in a sudden loss of sight. Examination reveals the inferior edge of both corneas had thinned so much that the normal intraocular pressure caused the weakened cornea to bulge. Because the edge of the cornea was involved a partial thickness corneal graft was needed to correct the pellucid marginal degeneration."

Description of Pre-Service Work: After the diagnosis has been made by performing comprehensive history and physical examination, the ophthalmologist counsels the patient about the procedure, complications, and expectations and special diagnostic procedures are done. Topographical corneal mapping is done to map out the surface topography of the affected area to be excised. Ultrasonic pachymetry is used to develop a corneal map showing the different thickness of the thin and healthy areas.

Description of Intra-Service Work: Under monitored local anesthesia or general anesthesia, the area of the diseased cornea to be excised is outlined on the surface of the cornea using the preoperative corneal map. The ultrasonic pachymeter may be used in surgery to confirm the junction of normal and thinned cornea. With a controlled depth-setting diamond blade knife set at a depth to cut partially into the thickness of the recipient's cornea, the diseased cornea is excised in a manner to allow a patch of lamellar graft to fit into the surgical site. A sheet of vinyl is used to make a pattern outlining the borders of the recipient's site and then is transferred onto the corneal surface of the whole donor globe. The diamond blade knife makes a partial thickness cut following the pattern. The edge of the cut is grasped and a layer of cornea of measured thickness is peeled off the donor globe with a knife. Aqueous is removed from the eye to soften the eye and the graft is then sutured in place with interrupted 10-0 nylon suture.

Description of Post-Service Work: The number of post-operative examinations depends on how well the patch graft heals. During the first month, there are at least three post-operative visits and then two monthly visits. During the post-operative period, the eye is monitored for infection, inflammation and healing problems. Sutures may be removed depending upon the rate of healing and vascularization.

SURVEY DATA:Specialty: American Academy of OphthalmologySample Size: 103 Response Rate (%): 28 Median RVW: 12.0025th Percentile RVW: 10.00 75th Percentile RVW: 13.60 Low: 7.00 High: 30.00Median Pre-Service Time: 35 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 65 75th Percentile Intra-Svc Time: 120 Low: 30 High: 140

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	<u> </u>
ICU:	<u> </u>	<u> </u>
Other Hospital:	<u> </u>	<u> </u>
Office:	<u>90</u>	<u>6</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	65285	Repair of eye wound	12.06
2)	67107	Scleral buckle procedure	13.99

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Lamellar keratoplasty is more complex than repairing corneal laceration. In repairing a corneal laceration, the edges of the wound are sutured together in a manner to achieve a water tight wound with the least impairment of visually important center of the cornea. In lamellar keratoplasty the diseased area of the cornea is partially excised and a partial thickness piece of donor tissue is cut to match the area of excised disease tissue and sutured in place. The lamellar keratoplasty requires skill to tailor the patch to fit the excised diseased area to achieve a smooth spherical corneal surface. The level of skill is greater than that requiring sewing the edges of the laceration together.

The subject code is about as complicated as repairing a retinal detachment with the scleral buckle procedure. A lamellar keratoplasty takes much more time and the precision of suturing and cutting is much greater than for a scleral buckle procedure. Because the corneal surgery has a greater impact on the post-operative refractive status of the greater technical skill is needed for lamellar keratoplasty.

The post-operative care of the lamellar keratectomy case is more intense than than for the repair of a corneal laceration or scleral buckle.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This is an uncommon procedure requiring a high level of skill. It has an additional difficulty because donor tissue is currently difficult to obtain because most donated tissue only involves part of the eye, the cornea, and a rim of sclera and not the whole eyeball. To harvest donor tissue for a lamellar keratectomy one needs a whole eyeball. The availability of whole globes has declined as eye banks have changed their harvesting procedures.

A high level of skill is necessary to design the shape and thickness of the donor material to the diseased area that needs to be excised. This match and size and size of graft to wound size would increase the chance of complications and reduce the chance of improving vision. The suturing is done with care, not to induce astigmatism or cause scarring in the visual axis.

This procedure requires a large number of post-operative visits to monitor the transplanted graft for healing problems and infections and time the removal of sutures.

Public Comments

30-Jun-95

Code: 65710

1995 RVUs: 9.52

Recommended RVUs: Inc

Ratio:

Long Descriptor: Keratoplasty (corneal transplant); lamellar

Reference Set (y/n): N

Global Period: 090

Frequency: 473

Impact:

Source: 7

Year: 93

Public Comment Letter: 459

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO, AAP

Societies Wishing to Comment: AOA-HCPAC

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
65710	53.8	0	46.2	53.8	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
65710	726	548	-13.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
65710	14.7	21.2	3.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
65710	ophthalmology	97.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
65710	360	3.8	DISORDERS OF THE GLOBE
	364	3.8	DISORDERS OF IRIS AND CILIARY BODY
	370	9.6	KERATITIS
	371	9.6	CORNEAL OPACITY AND OTHER DISORD
	372	3.8	DISORDERS OF CONJUNCTIVA
	379	3.8	OTHER DISORDERS OF EYE

Public Comments

30-Jun-95

909	3.8	LATE EFFECTS OF OTHER AND UNSPECI
V45	1.9	OTHER POSTSURGICAL STATES

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
65710							
AAOph		090	090	9.39	9.52	1.01	9.52

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
65710								
AAOph	9.52	9.52	1.01	1.00	1.00	1.00	INCR	459

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
65710								
AAOph	090	9.39		27	*	86		25

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
65710									
AAOph	*	1.0		10	0.0	*	0	0.0	4.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
65710									
AAOph	*	15		INCR	9.52	op	n		0.070

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Codes: 65730, 65750 & 65755 Global Period: 090 Current RVW: 11.83, 12.58, & 12.58
Recommended RVW: 13.50, 14.25, 14.25

CPT Descriptor: Keratoplasty (corneal transplant); penetrating except in aphakia

Source and Summary of Comment to HCFA on this service:

The AAO recommended that the values of these codes be increased.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A thirty-two year old woman with bilateral keratoconus can no longer tolerate the discomfort of wearing her custom fit contact lenses. The cornea is bulging and the apex of the cornea is now scarred and half of its normal thickness. Her best correctable vision is worse than 20/100. The irregular astigmatism is so severe that a keratometer could not measure the corneal surface irregularity."

Description of Pre-Service Work: After the diagnosis has been made by performing a comprehensive history and physical examination, the ophthalmologists counsels the patient about the procedure, complications and expectations, special diagnostic procedures are done. Topographical corneal mapping is done to map out the surface topography of the affected area to be excised. Ultrasonic pachymetry is used to develop a corneal map showing the different thickness of the thin and healthy areas. The size of the trephine cut is determined.

Description of Intra-Service Work: Under monitored local anesthesia or general anesthesia, the area of the diseased cornea to be excised is inspected to determine if the planned corneal trephine size is appropriate. A slightly larger corneal trephine is used to punch out the donor corneal tissue from the donor corneal-scleral tissue. A wire ring is sutured into episcleral tissue to prevent the eye from collapsing after trephination. The properly centered corneal trephine blade then partially cuts through the recipient cornea and the cut is completed with scissors taking care not to damage the iris or lens. After the cornea is removed, the donor corneal button is positioned with four sutures. The corneal button is sewed in place using a single 10-0 continuous running nylon suture, a double running 10-0 and 11-0 suture or a combination of interrupted and continuous sutures or just 16 interrupted stitches. The wound is then tested for leaks.

Description of Post-Service Work: The number of post-operative examinations depends on how well the corneal graft heals. During the first month, there is at least three post-operative visits ten visits every four to six weeks of the first year. During the post-operative period the eye is monitored for infection, inflammation, healing problems, and secondary glaucoma and transplant rejection. In some problematic cases, post-operative visits are as frequent as weekly during the first phase of surgery or during untoward effects of surgery. Approximately 10 weeks after surgery corneal topographical mapping is done. If there is significant residual irregularities; in the shape of the cornea the continuous running nylon suture may be adjusted at the slit lamp microscope in the office to reduce the astigmatism. The continuous running suture may be removed at one year or left in place indefinitely. Visual rehabilitation with glasses or contact lens is done at six months and needs to be repeated at one year. Patient is discharged from care about 15 months after surgery.

SURVEY DATA:Specialty: American Academy of OphthalmologySample Size: 103 Response Rate (%): 30 Median RVW: 13.5025th Percentile RVW: 12.54 75th Percentile RVW: 14.25 Low: 7.00 High: 24.00Median Pre-Service Time: 40 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 105 Low: 30 High: 160

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	<u> </u>
ICU:	<u> </u>	<u> </u>
Other Hospital:	<u> </u>	<u> </u>
Office:	<u>100</u>	<u>6</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	65285	Repair of eye wound	12.06
2)	67107	Scleral buckle procedure	13.99

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Penetrating keratoplasty is more complex than repair of the corneal transplant for several reasons. A transplant procedure requires obtaining donor tissue and cutting it for placement in the patients eye. The corneal laceration does not require additional tissue but just closure of the corneal tissue present.

A penetrating keratoplasty is just as complex as a scleral buckle procedure for retinal detachment but requires more intense care during the first 90 days. Because the effects of corneal surgery has a greater impact on the post-operative refractive status of the eye, greater attention is needed to suturing for the penetrating keratoplasty than for the scleral buckle.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Over the past five years, the amount of work to do corneal transplant has increased. Because of information received from corneal topography, the procedure is done frequently to follow the healing and the shape of corneal surface. If there is suture induced astigmatism, the sutures are adjusted during the first three months in hopes of achieving a spherically shaped cornea and the least amount of surgically induced astigmatism. Because of greater attention to try to achieve more than a clear graft and to try to achieve emmetropia -- good vision without optical correction -- greater stress is placed on the surgeon. In addition, there is added stress, in not causing a cataract from the surgical manipulation in patients with their own natural lenses.

Other connected procedures: 65750 and 65755. We originally recommend the same percentage change for these procedures because they are similar to survey procedure. The RUC's Multidisciplinary Workgroup 6 suggested an identical increment. We agree with the multi-disciplinary work group and have reduced our recommended increase.

Public Comments

30-Jun-95

Code: 65730 **1995 RVUs:** 11.83 **Recommended RVUs:** Inc **Ratio:**

Long Descriptor: Keratoplasty (corneal transplant); penetrating (except in aphakia)

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 6,435 **Impact:**

Source: 1 **Year:** 92 **Public Comment Letter:** 459

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO

Societies Wishing to Comment: AOA-HCPAC

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
65730	55.8	15.1	8.6	63.3	7	0	0	7.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
65730	8503	7015	-9.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
65730	19.8	14.4	-2.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
65730	ophthalmology	98.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
65730	366	9.3	CATARACT
	370	2	KERATITIS
	371	21.5	CORNEAL OPACITY AND OTHER DISORD
	379	1.5	OTHER DISORDERS OF EYE
	996	1.9	COMPLICATIONS PECULIAR TO CERTAI

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
65730							
AAOph		090	090	11.86	11.83	1.00	11.83
ASCat&RS		090	090	11.86	11.83	1.00	11.83

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
65730								
AAOph	11.83	11.83	1.00	1.00	1.00	1.00	INCR	459
ASCat&RS	11.83	11.83	1.00	1.00	1.00	1.00	13.50	286

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
65730								
AAOph	090	11.86		25		85		25
ASCat&RS	090	11.86		25		85		25

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
65730									
AAOph		1.0		10	0.5		10	0.0	5.5
ASCat&RS		1.0		10	0.5		10	0.0	5.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
65730									
AAOph		15		INCR	11.83	op	n		0.098
ASCat&RS		15		13.50	11.83	op	n		0.098

Public Comments

30-Jun-95

Code: 65750 1995 RVUs: 12.58 Recommended RVUs: 14.00 Ratio:

Long Descriptor: Keratoplasty (corneal transplant); penetrating (in aphakia)

Reference Set (y/n): N Global Period: 090 Frequency: 2,916 Impact: 4141

Source: 1 Year: 92 Public Comment Letter: 286

Reference Services:

CMD Comment:

Societies Wishing to Survey: AAO, AAP

Societies Wishing to Comment: AOA-HCPAC

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
65750	58	12.3	21	72.8	12.3	0	1.2	5

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
65750	5984	3254	-26.3

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
65750	21.8	15.2	-3.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
65750	ophthalmology	95.6
	other nonphysician prov	2.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
65750	364	2.2	DISORDERS OF IRIS AND CILIARY BODY
	365	1.5	GLAUCOMA
	366	2.5	CATARACT
	370	4.3	KERATITIS
	371	18.8	CORNEAL OPACITY AND OTHER DISORD

Public Comments

30-Jun-95

379	7.7	OTHER DISORDERS OF EYE
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
65750							
AAOph		090	090	12.76	12.58	0.99	12.58
ASCat&RS		090	090	12.76	12.58	0.99	12.58

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
65750								
AAOph	12.58	12.58	0.99	1.00	1.00	1.00	INCR	459
ASCat&RS	12.58	12.58	0.99	1.00	1.00	1.00	14.00	286

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
65750								
AAOph	090	12.76		22		89		25
ASCat&RS	090	12.76		22		89		25

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
65750									
AAOph		1.0		10	0.5		15	0.0	6.5
ASCat&RS		1.0		10	0.5		15	0.0	6.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
65750									
AAOph		15		INCR	12.58	op	n		0.088
ASCat&RS		15		14.00	12.58	op	n		0.088

Public Comments

30-Jun-95

Code: 65755

1995 RVUs: 12.58

Recommended RVUs: Inc

Ratio:

Long Descriptor: Keratoplasty (corneal transplant); penetrating (in pseudophakia)

Reference Set (y/n): N

Global Period: 090

Frequency: 9,613

Impact:

Source: 7

Year: 93

Public Comment Letter: 459

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO, AAP

Societies Wishing to Comment: AOA-HCPAC

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
65755	67.5	22.6	10	69.8	1.5	0	0	6.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
65755	7309	10731	21.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
65755	22	12.9	-4.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
65755	ophthalmology	98.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
65755	364	1.8	DISORDERS OF IRIS AND CILIARY BODY
	365	1	GLAUCOMA
	366	1.7	CATARACT
	370	2.2	KERATITIS
	371	20.1	CORNEAL OPACITY AND OTHER DISORD
	379	4.2	OTHER DISORDERS OF EYE

Public Comments

30-Jun-95

996	5.1	COMPLICATIONS PECULIAR TO CERTAI
V43	3.3	ORGAN OR TISSUE REPLACED BY OTHE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
65755							
AAOph		090	090	12.08	12.58	1.04	11.38
ASCat&RS		090	090	12.08	12.58	1.04	11.38

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
65755								
AAOph	12.58	12.58	0.94	1.11	1.00	1.00	INCR	459
ASCat&RS	12.58	12.58	0.94	1.11	1.00	1.00	14.00	286
S								

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
65755								
AAOph	090	12.08	.	.	.	.	.	.
ASCat&RS	090	12.08	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
65755									
AAOph
ASCat&RS
S									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
65755									
AAOph	.	.		INCR	12.58	op	3		
ASCat&RS	.	.		14.00	12.58	op	3		
S									

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 65855 Global Period: 090 Current RVW: 4.65 Recommended RVW: 4.15

CPT Descriptor: Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)

Source and Summary of Comment to HCFA on this service:

CMD Comment:

Recommended RVUs: 4.15

Reference Codes: 65860, 65865

Rationale for Change: Once the treatment series is completed, there are few follow up visits following 65855 unless there is uveitis or another complication. The procedure itself involves less time and intensity than 65865. In total work, it is closer to 65860 than 65865.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "65 year old African American male with uncontrolled intraocular pressure on maximally tolerated medical therapy has had progressive visual field loss and optic disc cupping. The patient has early cataracts. He states he is totally faithful with his medical regimen because he is very much afraid of going blind."

Description of Pre-Service Work: The preoperative laser history is filled out. The chart is reviewed and the laser is tuned. The eye is pre-treated with mioptic drops and the pressure is checked. The procedure and technique is explained to the patient and the patient is positioned at the laser and the appropriate laser settings are determined. Topical anesthetic drops are applied.

Description of Intra-Service Work: The laser gonio lens is placed on the cornea and gonioscopy is performed. The aiming beam is focused on the anterior trabeculum and tests are fired until pigment blending occurs. Between 60-100 beams are placed circumferentially. The lens is rinsed and the eye is irrigated and post treated with anti-coagulants and anti-inflammatory drops.

Description of Post-Service Work: Case is discussed with patient and family. Arrangements are made for a follow-up visit within 24 hours. Patient is seen, as appropriate, over next three months to ensure that normal inflammations subside. Visits typically occur at 1 day, 1 week, and 2 months. Operative notes are dictated and discussion with family takes place.

SURVEY DATA:

Specialty: American Academy of Ophthalmology

Sample Size: 103 Response Rate (%): 30 Median RVW: 4.65

25th Percentile RVW: 4.10 75th Percentile RVW: 4.95 Low: 1.75 High: 5.86

Median Pre-Service Time: 15 Median Intra-Service Time: 15

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 26.25 Low: 5 High: 60

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>10</u>	<u> </u>
ICU:	<u> </u>	<u> </u>
Other Hospital:	<u> </u>	<u> </u>
Office:	<u>30</u>	<u>3</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	65860	Incise inner eye adhesions	3.37
2)	65865	Incise inner eye adhesions	5.42
3)	66761	Revision of iris	3.77

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre-service time of 66761 is the same as 65855. The post-service time for 65855 is greater as is the intra-service time. The localization of the trabeculum is a dynamic process and requires more skill than 65860 or 65865. the post-operative time is greater for 65855 than for 65860, 65865 or 66761.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The CMD's incorrectly suggested that there are few follow-up visits for 65855. The original Harvard data found 3, 15 minute follow-up visits and this survey found 3, 10 minute follow-up visits. No time data is available on the reference codes suggested by the CMDs.

The respondents felt that 66761 was a more appropriate reference service than 65860 or 65865. The intra-service work is greater for 65855 than 66761.

The RUC Multidisciplinary Workgroup 6 rejected the CMD's rationale but, felt that the nature of the work for 65855 had decreased in the last couple of years because of the pre-operative use of newer anti-glaucoma drops. This agent dramatically reduced the intensity of the post-operative care on the day of the procedure thus decreasing the iatrogenic risk of post-operative visual field loss. For these reasons we accept the CMD RVW of 4.15.

CMD Comments

30-Jun-95

Code: 65855

1995 RVUs: 4.65

Recommended RVUs: 4.15

Ratio: -0.11

Long Descriptor: Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)

Reference Set (y/n): N Global Period: 090 Frequency: 158,017 Impact: -79008.5

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
65855			
65860	INCISE INNER EYE ADHESIONS	3.37	090
65865	INCISE INNER EYE ADHESIONS	5.42	090

CMD Comment:

Once the treatment series is completed, there are few follow up visits following 65855 unless there is uveitis or another complication. The procedure itself involves less time and intensity than 65865. In total work, it is closer to 65860 than 65865.

Societies Wishing to Survey: AAO, AAP

Societies Wishing to Comment: AOA-HCPAC, CLAO

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
65855	56.6	13.5	20.6	63.2	3.1	0.2	0.4	8.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
65855	173882	173166	-0.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
65855	1.3	0.6	-0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
65855	ophthalmology	98.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
65855	365	24.2	GLAUCOMA
	366	1.2	CATARACT

CMD Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
65855							
ASCat&RS		090	090	4.71	4.65	0.99	4.65
CMD		090	090	4.71	4.65	0.99	4.65

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
65855								
ASCat&RS	4.65	4.65	0.99	1.00	1.00	1.00	4.90	286
CMD	4.65	4.65	0.99	1.00	1.00	1.00	4.15	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
65855								
ASCat&RS	090	4.71		18		23		19
CMD	090	4.71		18		23		19

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
65855									
ASCat&RS		1.0		10	0.0		0	0.0	3.0
CMD		1.0		10	0.0		0	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
65855									
ASCat&RS		15		4.90	4.65	op	n		0.100
CMD		15		4.15	4.65	op	n		0.100

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 66180, 66170 & 66172 Global Period: 090 Current RVW: 12.63, 11.31, 13.67
Recommended RVW: 14.00, 11.26, 13.62

CPT Descriptor: Aqueous shunt to extraocular reservoir (eg Molteno, Schocket, Denver-Krupin)

Source and Summary of Comment to HCFA on this service:

The American Society of Cataract and Refractive Surgery recommended increasing this value to 14.00.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

This procedure was not surveyed.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	66170	Glaucoma surgery	11.31
2)	66172	Incision of eye	13.67

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

There exists a rank order anomaly in the glaucoma filtering codes. Codes 66180 is the most complex and least frequently used among these codes. We recommend an increase from 12.63 RVWs to 14 for 66180. The AAO feels that the base code for glaucoma filtering surgery, 66170, with 11.31 RVWs and glaucoma filtering with scarring from previous ocular surgery, 66172, with 13.67 RVWs are appropriately valued. If HCFA feels that it is necessary to make this change revenue neutral among this small family of codes, small reductions in 66170 and 66172 may be reasonable. Since the annual volume of 66170 and 66172 (59,000 approx.) dwarfs the number of 66180s, (2,000 approx.) the RVW reductions necessary to maintain budget neutrality should be no more than 0.05 RVWs.

The chart below is based on the latest available volume data provided by AMA's Kurt Gillis and the most current RVWs. It shows that this recommended changes would be revenue neutral.

CPT CODE	1994	1995	1994/1995	1996 (est.)	1996 (est.)	1996 (est.)
	NUMBER OF ALLOWED CHARGES	PER PROCEDURE RVWs	TOTAL ALLOWED RVWs	NUMBER OF ALLOWED CHARGES	PER PROCEDURE RVWs	TOTAL ALLOWED RVWs
66170	54,474	11.31	616,101	54,474	11.26	613,377
66172	8,039	13.67	109,893	8,039	13.62	109,491
66180	2,228	12.63	28,140	2,228	14.00	31,192
TOTAL	64,741	11.38	754,134	64,741	11.38	754,060

Public Comments

30-Jun-95

Code: 66180

1995 RVUs: 12.63

Recommended RVUs: 14.00

Ratio:

Long Descriptor: Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)

Reference Set (y/n): N Global Period: 090 Frequency: 2,106 Impact: 2885

Source: 5 Year: 93 Public Comment Letter: 286

Reference Services:

CMD Comment:

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Societies Wishing to Survey:

Societies Wishing to Comment: AAO, AOA-HCPAC

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
66180	43.9	10.6	29.7	59.1	13.6	0	0	3.1

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
66180	1843	2228	10

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
66180	28.6	18.9	-4.9

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
66180	ophthalmology	97.3

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
66180	364	1.9	DISORDERS OF IRIS AND CILIARY BODY
	365	24.6	GLAUCOMA
	379	1.5	OTHER DISORDERS OF EYE

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
66180							
ASCat&RS		090	090	11.58	12.63	1.09	10.80

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
66180								
ASCat&RS	12.63	12.63	0.93	1.17	1.00	1.00	14.00	286
S								

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
66180								
ASCat&RS	090	11.58						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
66180									
ASCat&RS									
S									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
66180									
ASCat&RS				14.00	12.63	op	3		
S									

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 66821 Global Period: 090 Current RVW: 2.78 Recommended RVW: 2.78

CPT Descriptor: Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg. YAG laser) (one or more stages)

Source and Summary of Comment to HCFA on this service:

CMD Comments

Recommended RVUs: 2.30

Reference Codes: 66820

Rationale for Change: The technical skill and work intensity for 66821 are significantly lower than 66820. Intra-service time is about half. Outpatient visits are fewer.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "Eight months after surgery, a 70-year old female complains of diminished vision in her operated eye. An eye examination reveals posterior capsular opacification of sufficient severity to warrant treatment. Laser surgery is performed. The patient is examined postoperatively for signs of complications."

Description of Pre-Service Work: A complete ophthalmological examination is performed, including slit lamp examination and fundusopic examination. It is noted that the patient has decreased visual acuity and opacification of the posterior capsule. Careful examination of the macula including use of the potential acuity meter is required to rule out macular diseases that cause visual loss. Informed consent is obtained. Patients chart, past history and last ocular examination are reviewed. Topical steroids, anti-glaucoma medications, and topical anesthetic are instilled.

Description of Intra-Service Work: The patient is seated at the laser, and a contact lens is applied. Multiple applications of laser energy are delivered, caution being taken not to damage the intraocular lens implant or other structures. Test burns are applied to confirm the adequacy of the YAG energy, the burst mode and the power are adjusted to achieve optimal vaporization.

Description of Post-Service Work: The patient is monitored approximately two hours after the procedure for elevated intraocular pressure, which is a recognized complication of YAG laser capsulotomy. In the case of elevated intraocular pressure, medical treatment is usually sufficient for control. The patient is seen one to two weeks following the procedure for a refraction and evaluation of the results of treatment. The patient is seen again at one to three months following the procedure for a dilated retina examination to look for evidence of retinal hole formation or retinal detachment.

CPT Code: 66821

SURVEY DATA:

Specialty: American Academy of Ophthalmology

Sample Size: 103 Response Rate (%): 32 Median RVW: 3.42

25th Percentile RVW: 3.00 75th Percentile RVW: 3.76 Low: 2.40 High: 7.98

Median Pre-Service Time: 15 Median Intra-Service Time: 11

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 15 Low: 4 High: 100

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>10</u>	<u> </u>
ICU:	<u> </u>	<u> </u>
Other Hospital:	<u> </u>	<u> </u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	66761	Revision of iris	3.77
2)	66820	Incision, secondary cataract	3.76
3)	67031	Laser surgery, eye strands	3.42

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The pre-service work of 66821 is almost identical with that 66761, 67031, and 66820. The intra-service skill and complexity of 66821 is the same as 66761 and 67031 but is less the time and complexity 66820. The post-operative care and time are similar for all three. The iatrogenic risks and complications for 66821 and the open procedure, 66820, are the same and include a 2% incidence of retinal detachment. The dissection of a secondary membrane using an open technique, 66820, has the same pre-service and post-service work as the closed procedure performed with the YAG laser, 66821, but does involve more intra-service time. They both have the same risk of retinal detachment.

The RUC has adopted the policy of valuating open and closed procedures the same i.e., laparoscopic versus open cholecystectomy. Currently, 66821, the "closed procedure" for opening opacified posterior capsule is valued at 2.78 work RVWs while the "open procedure", 66820 is valued higher at 3.76. For these reasons the AAO feels that YAG capsulotomy is not overvalued and recommends that the current RVW of 2.78 be retained.

CMD Comments

30-Jun-95

Code: 66821 1995 RVUs: 2.78 Recommended RVUs: 2.30 Ratio: -0.17

Long Descriptor: Discussion of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (one or more stages)

Reference Set (y/n): N Global Period: 090 Frequency: 588,742 Impact: -282596.16

Source: 7 Year: 93 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
66821			
	66820 INCISION, SECONDARY CATARACT	3.76	090

CMD Comment:

The technical skill and work intensity for 66821 are significantly lower than 66820. Intraservice time is about half. Outpatient visits are fewer.

Societies Wishing to Survey: AAO

Societies Wishing to Comment: AOA-HCPAC, CLAO

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
66821	68.1	19.5	8	70.3	1.9	0.1	0.4	14.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
66821	622842	651908	2.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
66821	1	0.5	-0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
66821		
	ophthalmology	91.5
	other nonphysician prov	7.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
66821			
	366	24.1	CATARACT
	V43	2.5	ORGAN OR TISSUE REPLACED BY OTHE

CMD Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
66821							
CMD		090	090	2.73	2.78	1.02	2.78

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
66821								
CMD	2.78	2.78	1.02	1.00	1.00	1.00	2.30	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
66821								
CMD	090	2.73		11		15		17

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
66821									
CMD		0.5		10	0.0		0	0.0	2.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
66821									
CMD		10		2.30	2.78	xx	n		0.084

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 67312 Global Period: 090 Current RVW: 7.55 Recommended RVW: 8.19

CPT Descriptor: Strabismus surgery, recession or resection procedure (patient not previously operated on); two horizontal muscles

Source and Summary of Comment to HCFA on this service:

The American Academy of Ophthalmology and the American Academy of Pediatrics recommended that the work valued of this procedure be increased.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A 6 year old boy developed comitant estropia at age 5 years. A severe amblyopia in the right eye developed. The amblyopia was partially corrected by patching. The patient's parents consented to the repair of the strabismus to restore the ocular alignment and single binocular vision. The patient was placed under general anesthesia and the face and eyes prepped. The right medial rectus muscle was isolated, placed on an absorbable suture, detached from the globe, and recessed 5 mm reattaching the muscle to the globe with two scleral passes of the suture. The right lateral rectus muscle was isolated, the anterior portion resected 7 mm, and the remaining muscle then reattached to the globe with sutures through the sclera. Separate conjunctival incisions were used for each of the muscles operated. The patient returned for post-operative examinations on post-operative days 2, 14, 28, and 63."

Description of Pre-Service Work: The chart and physical examination are reviewed. The pre-operative outpatient history and physical form is completed. The patient is briefly examined in the pre-op area to check for infection. The surgical plan is reviewed. The patients family is counseled in the pre-op area prior to induction. Topical medications are ordered and applied.

Description of Intra-Service Work: 67312 requires two conjunctival incisions, at least four scleral passes and 50 percent more operative time and effort than that required for 67311. (67311 requires two scleral passes without one muscle operated). With each muscle, there is a separate conjunctival incision, identification of the muscle, separation of the muscle from its fascial attachments, imbrication of the muscle with suture and replacement of the muscle on the surface of the globe by means of high risk, low margin for error scleral passage. Each passage carries a risk for scleral perforation (penetration of the needle to the underlying choroid or retina) with the possibility of intraocular infection (endophthalmitis, intraocular hemorrhage or retinal detachment).

With CPT 67312 there are twice as many scleral passes as with 67311 and therefore twice the risk of scleral perforation. This event is associated with many complications.

The average length of operative time to complete 67312 is twice that required for 67311.

Description of Post-Service Work: The post service work for 67312 is approximately the same as for 67311. The work includes one follow up exam (office) within the first week of surgery. During this exam the vision in each eye is compared to pre-operative values, the motility and muscle balance are assessed and slit lamp and fundus exams are performed to rule out the possibility of occult perforation, intraocular or periocular infection or dry spots on the cornea due to sub optimal corneal lubrication.

Two or three additional exams occur during the post operative period. These include all of the above mentioned procedures plus refraction, placement of compensatory temporary prisms and institution of eye muscle exercises (orthoptics) if necessary.

Lens prescription changes, if necessary, are made during one of the post operative exams.

SURVEY DATA: None gathered

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	63780	Insertion of subarachnoid catheter	6.22
2)	49525	Repair of inguinal hernia	6.97
3)	66850	Removal of lens material	8.66
4)	67412	Revise two eye muscles	9.14

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 67311 (one horizontal muscle) is the most common eye muscle operation performed in this country and is felt to be the "index procedure" to which all eye muscle procedures are compared. 67311 has a RVW of 6.30 units. It is bracketed by codes 63780 (Insertion of subarachnoid catheter) at 6.55 and CPT 49520 (Repair of inguinal hernia, any age, recurrent) at 6.97.

From discussion with colleagues in other specialties and other areas of ophthalmology we feel that 67311 appears to be fairly placed between these two reference services when time required, mental effort and judgement, technical skill and stress are taken into account.

67312 requires twice the operative effort as 67311. We believe the work is greater in scope than 66850 (8.66) but less than 67412 (9.14).

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

67312 represents a doubling of the intra-service work, or essentially performing a second surgery through a second incision compared to 67311. HCFA has previously noted that a second procedure generally warrants 50% of the recommended value to account for the increased intra-service work. We concur with this opinion. 67311, which is a single muscle operation, has a relative work value of 6.3 units. We believe that 67312 should have an incremented value of approximately 50% or 3.15 additional work value units. This increase acknowledges that the increase should not be applied to the other components of total work.

The proposed value of 9.0 is consistent with the idea that a second procedure is being performed on these patients with a second separate intra-service work. We acknowledge that pre-service and post-service work for the procedure are essentially identical. For that reason, we recommend a relative value of 9.0 units, slightly less than a 50% increment of the value of the parent procedure 67311.

We believe that this procedure is fairly placed with this relative value between codes 66850 and 67412. We believe that the work involved in a two muscle operation exceeds that in a unilateral inguinal hernia repair but would be similar to that of a bilateral hernia repair. Of additional note, most of these procedures are performed on children with extended pre-service time for discussion with parents as well as appropriate child discussions that were not part of the initial Hsiao studies or the surveys of ophthalmologists.

The AAO accepts the multi-disciplinary work groups methodology for increasing the RVW of 67312 to 8.19.

Public Comments

30-Jun-95

Code: 67312

1995 RVUs: 7.55

Recommended RVUs: 9.00

Ratio:

Long Descriptor: Strabismus surgery, recession or resection procedure (patient not previously operated on); two horizontal muscles

Reference Set (y/n): N **Global Period:** 090 **Frequency:** 1,646 **Impact:** 2387

Source: 4 **Year:** 93 **Public Comment Letter:** 459

Reference Services:

CMD Comment:

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Societies Wishing to Survey:

Societies Wishing to Comment: AAO, AOA-HCPAC

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
67312	36.4	3.6	16.4	58.2	21.8	0	0	16.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
67312	1997	1808	-4.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
67312	3.3	2.8	-0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
67312	ophthalmology	96.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
67312	366	2.3	CATARACT
	378	26.4	STRABISMUS AND OTHER DISORDERS O

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
67312								

Public Comments

30-Jun-95

AAOph	090	090	7.29	7.55	1.04	7.55
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Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
67312								
AAOph	7.55	7.55	1.04	1.00	1.00	1.00	9.00	459

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
67312								
AAOph	090	7.29		19		54		30

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
67312									
AAOph		0.5	*	10	0.0		0	0.0	3.5

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
67312									
AAOph		15		9.00	7.55	op	n		0.082

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 67316 Global Period: 090 Current RVW: 8.02 Recommended RVW: 9.26

CPT Descriptor: Strabismus surgery, recession or resection procedure (patient not previously operated on); two or more vertical muscles (excluding superior oblique)

Source and Summary of Comment to HCFA on this service:

The AAO & AAPed recommended an increases in the RVWs of this procedure.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A 65 year old patient suffered a brainstem infarction, which resulted in a unilateral upgaze paresis of the left eye. the eye movements did not recover over one year and the patient was troubled with vertical diplopia. The patient was taken to the operating room. Intravenous sedation was administered. Local infiltration anesthesia was performed in the left orbit. The inferior rectus muscle was localized through an inferior conjunctival incision, placed on a suture, disinserted from the globe, and recessed. The superior rectus muscle was approached through a superior conjunctival wound, isolated, 7 mm removed, and then reattached to the surface of the globe with sutures. The conjunctival wounds were closed. The patient was followed up on postoperative days 1, 7, 28, and 56.

Description of Pre-Service Work: The chart and physical examination are reviewed. The pre-operative outpatient history and physical form is completed. The patient is briefly examined in the pre-op area to check for infection. The surgical plan is reviewed. The patients family is counseled in the pre-op area prior to induction. Topical medications are ordered and applied.

Description of Intra-Service Work: 67316 requires two conjunctival incisions, at least four scleral passes and 50 percent more operative time and effort than that required for 67314. (67311 requires two scleral passes without one muscle operated). With each muscle, there is a separate conjunctival incision, identification of the muscle, separation of the muscle from its fascial attachments, imbrication of the muscle with suture and replacement of the muscle on the surface of the globe by means of high risk, low margin for error scleral passage. Each passage carries a risk for scleral perforation (penetration of the needle to the underlying choroid or retina) with the possibility of intraocular infection (endophthalmitis, intraocular hemorrhage or retinal detachment).

With CPT 67316 there are twice as many scleral passes as with 67314 and therefore twice the risk of scleral perforation. This event is associated with many complications.

The average length of operative time to complete 67316 is twice that required for 67314.

Description of Post-Service Work: The post service work for 67316 is approximately the same as for 67314. The work includes one follow up exam (office) within the first week of surgery. During this exam the vision in each eye is compared to pre-operative values, the motility and muscle balance are assessed and slit lamp and fundus exams are performed to rule out the possibility of occult perforation, intraocular or periocular infection or dry spots on the cornea due to sub optimal corneal lubrication.

Two or three additional exams occur during the post operative period. These include all of the above mentioned procedures plus refraction, placement of compensatory temporary prisms and institution of eye muscle exercises (orthoptics) if necessary. Lens prescription changes, if necessary, are made during one of the post operative exams.

SURVEY DATA: None collected

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	63780	Insertion of subarachnoid catheter	6.22
2)	49525	Repair of inguinal hernia	6.97
3)	66850	Removal of lens material	8.66
4)	67314	Revise eye muscle	7.12

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

67316 represents a doubling of the intra-service work, or essentially performing a second surgery through a second incision compared to 67314. HCFA has previously noted that a second procedure generally warrants 50% of the recommended value to account for the increased intra-service work. we concur with this opinion. 67314, which is a single muscle operation, has a relative work value of 7.12 units. We believe that 67316 should have an incremented value of approximately 50% or 3.56 additional work value units. This increase acknowledges that the increase should not be applied to the other components of total work.

The proposed value of 9.5 is consistent with the idea that a second procedure is being performed on these patients with a second separate intra-service work. We acknowledge that pre-service and post-service work for the procedure are essentially identical. For that reason, we recommend a relative value of 9.5 units, slightly less than a 50% increment of the value of the parent procedure 67314.

Of additional note, most of these procedures are performed on children with extended pre-service time for discussion with parents as well as appropriate child discussions that were not part of the initial Hsiao studies or the surveys of ophthalmologists.

The AAO accepts the RUC multi-disciplinary work groups methodology. Therefore we have lowered our recommended new value to 9.26.

Public Comments

30-Jun-95

Code: 67316

1995 RVUs: 8.02

Recommended RVUs: 9.50

Ratio:

Long Descriptor: Strabismus surgery, recession or resection procedure (patient not previously operated on); two or more vertical muscles (excluding superior oblique)

Reference Set (y/n): N Global Period: 090 Frequency: 181 Impact: 268

Source: 4 Year: 93 Public Comment Letter: 459

Reference Services:

CMD Comment:

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Societies Wishing to Survey:

Societies Wishing to Comment: AAO, AOA-HCPAC

Trends Analysis - Beneficiary Information:

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
67316	236	188	-10.7

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
67316	8.1	3.2	-2.4

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
67316	group practices	2.1
	ophthalmology	95.7

Claims-Level Diagnosis Information:

Harvard Data:

Harvard Data:

Public Comments

30-Jun-95

Harvard Data:

Comm	Pack95	Hrvtotwk	Notatw	Pret	Svdpre	ltime	Notett	Imppt
67316								
AAOph	090	6.65						

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
67316									
AAOph									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
67316									
AAOph				9.50	8.02	op	3		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 67420 Global Period: .090 Current RVW: 13.36 Recommended RVW: 19.00

CPT Descriptor: Orbitotomy with bone flap or window, lateral approach (e.g. Kroenlein); with removal of lesion

Source and Summary of Comment to HCFA on this service:

The AAO recommended an increase in the work value of this procedure.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A 68 year old gentleman is referred to his ophthalmologist by his primary care physician because of unilateral proptosis of the right eye. The patient has complained of double vision for two weeks. A CT scan of the orbit reveals a well-circumscribed, intraconal mass which is lateral and superior to the optic nerve. It slightly enhances with contrast."

Description of Pre-Service Work: Admission protocols for hospitalization are carried out. Once in the operating room and after general anesthesia is induced, patient is positioned as necessary to perform the procedure. Ancillary equipment such as microscope, ultrasound or laser are prepared for use.

Description of Intra-Service Work: The operation is performed in some cases via lateral canthotomy incision which provides exposure to the superior maxilla and inferior frontal bone as well as the zygoma and the zygomatic arch. Often a bicoronal incision is required as well, to provide access to the superior orbital regions. Additional removal of this rim is frequently required to provide adequate visualization of the tumor. Intraorbital dissection follows the removal of bone and this proceeds deliberately to avoid injury to the nerves (including the optic nerve) that innervate the eyeball as well as extraocular muscles. The tumor is first isolated out and then a series of maneuvers are carried out to further define isolate the tumor from the surrounding tissues to prevent harm during removal of the tumor. Once the proper protective measures have been instituted, the tumor is removed, usually under microscopic control. This process usually requires one to two hours. Following the removal of the tumor the bone is replaced and fixated with mini plates and the skin wounds are closed.

Description of Post-Service Work: The postoperative work includes monitoring of the patient closely during the first 24 hours. The patient is then examined on a daily basis and is usually discharged within 3-5 days after surgery. The postoperative care is directed toward providing the appropriate wound care instructions and monitoring for appropriate healing.

CPT Code: 67420

SURVEY DATA:

Specialty: American Academy of Ophthalmology

Sample Size: 103 Response Rate (%): 28 Median RVW: 20.00

25th Percentile RVW: 17.00 75th Percentile RVW: 21.80 Low: 12.00 High: 30.00

Median Pre-Service Time: 60 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 200 Low: 60 High: 360

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>35</u>	<u> </u>
ICU:	<u>30</u>	<u>1</u>
Other Hospital:	<u>30</u>	<u>2</u>
Office:	<u>90</u>	<u>5</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	67107	Repair of retinal detachment, scleral buckling	13.99
2)	21267	Orbital repositioning, periorbital osteotomies	17.66
3)	67108	Repair of retinal detachment; with vitrectomy	19.90
4)	21433	Open treatment of craniofacial separation	23.69

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above. See below.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Comparing a lateral orbitotomy with removal of lesion (67420) is easily demonstrated using the above reference codes. The current RVW of 13.36 is undervalued. Pre-service time, effort and skill for a scleral buckling of a retinal detachment (67107) {RVW 13.99} is less than the lateral orbitotomy (67420) since the orbitotomy requires the review of CT or MR scans, consultation with non-ophthalmic surgeons such as neurosurgeons and/or otolaryngologists (depending on the size and position of the lesion), and coordination with other physicians to rule out possible systemic origins of the lesion such as metastatic disease elsewhere or, for example, systemic lymphoma with orbital involvement.

Intra-service time, effort, skill and stress is greater than orbital repositioning (21267) {RVW 17.66} because the lateral orbitotomy requires the removal of an orbital lesion along with the osteotomies to remove the lateral orbital bone. Orbital repositioning does not involve manipulation of the delicate intraorbital tissues and structures in order to remove a lesion that is usually intimately attached to these structures. Similar orbitotomy techniques are used in both, however, no bone grafts are required in the lateral orbitotomy (the lateral orbital bone, however, is repositioned and replaced as if it was a grafted material).

The intra-service work time is less than an open treatment of craniofacial separation (21433) {RVW 23.69}, however, the effort, skill and stress are probably quite similar.

The post-service work and effort of the lateral orbitotomy is slightly less than that of a repair of retinal detachment with vitrectomy (67108) {RVW 19.90}, however, the pre-service work and effort is greater for the reasons mentioned above (see comparison with 67107). The intra-service time would be very comparable related to effort, skill, stress and time. This would place the appropriate RVW value slightly higher than 67108 (RVW 19.90) and much lower than 21433 (RVW 23.69).

An RVW value of 19.00 is suggested to reflect these differences in pre-, intra-, and post-service work time, effort stress, and skill which is significantly higher than 67107 (RVW 13.99), slightly lower than 67108 (RVW 19.90) but lower than 21433 (RVW 23.69).

Public Comments

30-Jun-95

Code: 67420

1995 RVUs: 13.36

Recommended RVUs: 25.00

Ratio:

Long Descriptor: Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion

Reference Set (y/n): N

Global Period: 090

Frequency: 165

Impact: 1921

Source: 4

Year: 93

Public Comment Letter: 459

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO, AAP

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
67420	50	0	0	83.3	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
67420	186	201	4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
67420	46.8	40.3	-3.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
67420	ophthalmology	90.5
	plastic surgery	3.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
67420	190	8.3	MALIGNANT NEOPLASM OF EYE
	224	4.2	BENIGN NEOPLASM OF EYE
	239	4.2	NEOPLASMS OF UNSPECIFIED NATURE
	242	4.2	THYROTOXICOSIS WITH OR WITHOUT G
	376	8.3	DISORDERS OF THE ORBIT

Public Comments

30-Jun-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
67420							
AAOph		090	090	13.62	13.36	0.98	13.36

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
67420								
AAOph	13.36	13.36	0.98	1.00	1.00	1.00	25.00	459

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
67420								
AAOph	090	13.62		34	*	135		38

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
67420									
AAOph		0.5	*	10	0.5	*	15	0.0	6.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
67420									
AAOph	*	15		25.00	13.36	op	3		0.069

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 68720 Global Period: 090 Current RVW: 7.68 Recommended RVW: 8.56

CPT Descriptor: Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)

Source and Summary of Comment to HCFA on this service:

The AAO recommended an increase for this procedure.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A 72 year old female is referred to her ophthalmologist with a swollen area over her right lacrimal sac. She admits to a 6 month history of chronic tearing and has been treated for chronic conjunctivitis for at least the last 4 months. Pressure on the lacrimal sac reveals a purulent reflux through the lower canaliculus. Irrigation of the right lacrimal system reveals a blockage distal to the common canaliculus."

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:Specialty: American Academy of OphthalmologySample Size: 103 Response Rate (%): 31 Median RVW: 11.1725th Percentile RVW: 8.94 75th Percentile RVW: 12.13 Low: 6.52 High: 14.00Median Pre-Service Time: 40 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 40 High: 150

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	<u> </u>
ICU:	<u> </u>	<u> </u>
Other Hospital:	<u> </u>	<u> </u>
Office:	<u>60</u>	<u>4</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	21385	Repair eye socket fracture	8.56
2)	21275	Revision of orbitofacial bones	10.50

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

See below.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The current RVW for a dacryocystorhinostomy (DCR) is undervalued at 7.68. When compared to the above reference codes, it should be valued somewhere between open treatment of an orbital floor fracture (Caldwell-Luc procedure) (21285) {RVW 8.56} and secondary revision of orbitocraniofacial reconstruction (21275) {RVW 10.50}. All three procedures require techniques and skills that cross multiple surgical disciplines, i.e., ophthalmology and otolaryngology, since both the orbit and the sinus/nasal cavity is involved.

Pre-service time is relatively similar in the DCR and the Caldwell-Luc (C-L). The procedure requires reviewing scans pre-operatively since fractures are present. The DCR requires more of a pre-operative work-up since the source of "tearing" must first be determined. Tear dye disappearance tests and lacrimal system irrigation is routinely performed. The latter has a separate CPT code but is not paid on the same day as the consultation or examination when it is done. Typically, the DCR requires extra pre-service time to reduce or resolve the acute infectious process (acute dacryocystitis) leading to the blockage in the lacrimal apparatus. The orbital fracture is a one time event awaiting repair.

Intra-service time is definitely more in the DCR than the C-L. Both require entry incisions (skin in the DCR, mucosa in the C-L). Both require osteotomies. The DCR is performed in a smaller space. Reduction of the fracture is very similar to creating preparing the nasal mucosa and lacrimal sac flaps. The DCR includes intubation of the lacrimal system with silicone tubing. The C-L has no such comparison. The closures are similar in both. Both have the risk of juxtabulbar or retrobulbar hemorrhage with subsequent visual compromise.

The post-service time and effort is significantly different due to the addition of an extra procedure that is associated with the DCR and not the C-L. Usually around 3 months post-operative, the silicone tubing must be removed in the office which requires an instrument set-up and procedure. The lacrimal system is, once again, irrigated to confirm the patency of the lacrimal system. These procedures are included in the DCR code.

An RVW value of 8.81 suggested to reflect these differences in pre, intra, and post-service work time, effort, stress and skill. This is moderately higher than the C-L procedure (21385) {RVW 8.56} and substantially lower than the secondary revision of orbitocraniofacial reconstruction (21275) {RVW 10.50}. However, the AAO accepts the multi-disciplinary work group recommendation of 8.56.

Public Comments

30-Jun-95

Code: 68720

1995 RVUs: 7.68

Recommended RVUs: 11.56

Ratio:

Long Descriptor: Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)

Reference Set (y/n): N Global Period: 090 Frequency: 4,890 Impact: 18973

Source: 4 Year: 93 Public Comment Letter: 459

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAO, AAP

Societies Wishing to Comment: AOA-HCPAC

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
68720	59.1	14.4	5.3	80.3	3.8	0	0	12.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
68720	5411	5295	-1.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
68720	15.8	8.3	-3.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
68720	ophthalmology	89.8
	otolaryngology	5.5
	plastic surgery	2.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
68720	374	2.3	OTHER DISORDERS OF EYELIDS
	375	29.2	DISORDERS OF LACRIMAL SYSTEM

Harvard Data:

Public Comments

30-Jun-95

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
68720							
AAOph		090	090	7.66	7.68	1.00	7.68

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
68720								
AAOph	7.68	7.68	1.00	1.00	1.00	1.00	11.56	459

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
68720								
AAOph	090	7.66		19		83		25

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
68720									
AAOph		0.5		10	0.0		0	0.0	3.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
68720									
AAOph		15		11.56	7.68	op	n		0.061

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Codes: 92018 & 92019¹ Global Period: ~~XXX~~ Current RVW: 1.51 & 1.31 Recommended RVW: 2.50 & 2.17

CPT Descriptor: Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete

Source and Summary of Comment to HCFA on this service:

CMD Comments:²

Recommended RVUs: 0.88

Reference Codes: 57400, 57410, 45910, 99215

Rationale for Change: This is usually done for evaluation of a child. The ophthalmologist may need to bring additional equipment, but this procedure is no more difficult and the risk is no more greater than 57400, 57410 and is certainly not the same as 99215 (the most difficult return office visit patient).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A 3 month old male is referred by his pediatrician for cloudy corneas. Epiphora has been present for 3-4 weeks. The right cornea is enlarged and edematous with no fundus view. The left eye is mildly edematous. There are no apparent Descemet breaks. Retinoscopy cannot be accomplished. Discomfort and photophobia prevent meaningful measurement of intraocular pressure in the office."

Description of Pre-Service Work: The chart and physical examination are reviewed. The pre-operative outpatient history and physical form is completed. The patient is briefly examined in the pre-op area to check for infection. The surgical plan is reviewed. The patients family is counseled in the pre-op area prior to induction. Topical medications are ordered and applied

¹ 92019 represents a limited ophthalmological examination under anesthesia. This means that a detailed examination of an affected portion of the eye is performed. These are typically performed in children who are monitoring intraocular pressure associated with glaucoma surgery or following corneal transplant, or patients who cannot be examined in the office. The medical decisionmaking, like that of 92018, is typically of high complexity.

The RVW for 92019 currently is 1.31. Based upon the detailed examination and a level of medical decisionmaking similar to that found for 92018, we believe that the value of this procedure should be increased rather than decreased. A similar percentage increase would raise the value of this procedure to 2.16 RVWs. This would be less than 99244, an office consultation, or 99205, an office outpatient visit. However, because of the high complexity of the medical decisionmaking, and the detailed examination, it should be more than that for 99215. We therefore believe that it is logical to extrapolate to 2.17 RVWs.

² For 92019, CMD's cited same reference procedures and recommended a reduction from 1.31 to 0.38 and the only rationale was "This is reduced by the same percentage as 92018." Note: the CMD's math was incorrect.

Description of Intra-Service Work: A standardized form is used to record data during the EUA. Intraocular pressure is measured immediately upon adequate anesthesia prior to intubation. Other parts are completed after intubation. Horizontal corneal diameter is measured with a caliper. The slit lamp is used to examine the anterior segment if available. The operative microscope is used with a gonioscopy lens to examine the chamber angle. Direct and indirect ophthalmoscopy are used to examine the posterior segment. If possible a careful scleral depression examination of the entire retina is performed. Refraction is performed using the retinoscope and trial lens bar if the view permits. The data obtained is analyzed and a decision made to awaken the patient or to proceed with other procedures based on the EUA data and the desires of the family obtained pre-operatively.

Description of Post-Service Work: The data obtained is presented and interpreted for family. Appropriate follow up or additional procedure arrangements are made. Letters are dictated to other physicians.

SURVEY DATA:

Specialty: American Academy of Ophthalmology

Sample Size: 115 Response Rate (%): 24 Median RVW: 2.50

25th Percentile RVW: 2.00 75th Percentile RVW: 3.50 Low: 1.47 High: 5.00

Median Pre-Service Time: 30 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 45 Low: 10 High: 90

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	<u> </u>
ICU:	<u> </u>	<u> </u>
Other Hospital:	<u> </u>	<u> </u>
Office:	<u> </u>	<u> </u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	57400	Dilation of vagina	0.83
2)	57410	Pelvic examination	0.59
3)	45910	Dilation of rectal narrowing	1.86
4)	99215	Office/oupatient visit, est.	1.51
5)	99205	Office/Outpatient visit, new	2.28
6)	99223	Initial hospital care	2.57

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

See below.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Code 92018 is a complete ophthalmological examination of a single system of the body, the eye, albeit under anesthesia. The intra-service work is complicated by the fact that most of these patients are children, most have severe ocular problems, usually cataract, aphakia, corneal scarring, graft or transplant, or glaucoma. These complicated problems create substantial medical decisionmaking. Pre-service work is far more than would be for an outpatient examination in that the patient has to be seen and the parents consented for a procedure under general anesthesia. As with any pediatric patient, this requires extensive discussion and explanation with the patients parents.

Survey data reveal a total service time of 75 minutes f the physician in attendance with the family. Appropriate reference procedures might include 99205 with 60 minutes face-to-face time with 2.28 RVWs and 99223, an in-patient evaluation and management service with 70 minutes and 2.57 RVWs. Survey data by the American Academy of Ophthalmology found a median RVW of 2.5. We, therefore, propose 2.5 RVW as a value for this undervalued procedure. This procedure cannot be reported if another intervention is performed.

With respect to the comparison of this procedure with dilation of vagina (57400) or pelvic examination (57410) under anesthesia, there is no comparison. This ophthalmological procedure carries a comprehensive ophthalmological examination rather than a portion of the gynecological examination. Further, this is often performed on a pediatric patient which makes the examination more complicated. There is substantial medical decisionmaking associated with the typical diagnosis of glaucoma, cataract and aphakia that far exceed the medical decisionmaking found with the reference procedures noted by the carrier medical directors. Harvard data for those two codes revealed 40 minutes total time for 57400 and 33 minutes for 57410. We believe that, based upon the high complexity of the medical decisionmaking as well as the comprehensive examination required for 92018, the work exceeds that required for the work of 99215. In addition, there is pre-service examination including history that must be part of this examination which is not accounted for in 99215.

CMD Comments

06-Jul-95

Code: 92018

1995 RVUs: 1.51

Recommended RVUs: 0.88

Ratio: -0.42

Long Descriptor: Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 1,710 **Impact:** -1077.3

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
92018			
45910	DILATION OF RECTAL NARROWING	1.86	010
57400	DILATION OF VAGINA	0.83	000
57410	PELVIC EXAMINATION	0.59	000
99215	OFFICE/OUTPATIENT VISIT, EST	1.51	XXX

CMD Comment:

This is usually done for evaluation of a child. The ophthalmologist may need to bring additional equipment, but this procedure is no more difficult and the risk is no greater than 57400, 57410 and is certainly not the same as 99215 (the most difficult return office visit patient).

Societies Wishing to Survey: AAO

Societies Wishing to Comment: ACEP, AOA-HCPAC

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
92018	38.5	7.7	20	57.7	23.1	0	0	14.3

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
92018	2047	1800	-6.2

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
92018	10.3	9.3	-0.5

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
92018		
	anesthesiology	15.4
	group practices	2.6
	ophthalmology	59.2
	other nonphysician prov	18.6

CMD Comments

06-Jul-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
92018			
	361	1.9	RETINAL DETACHMENTS AND DEFECTS
	362	1.9	OTHER RETINAL DISORDERS
	365	4.8	GLAUCOMA
	366	12.5	CATARACT
	370	2.9	KERATITIS
	379	3.8	OTHER DISORDERS OF EYE
	758	1.9	CHROMOSOMAL ANOMALIES
	871	3.8	OPEN WOUND OF EYEBALL

Harvard Data:

	Comm	Modif	Packthv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
92018								
	CMD		XXX	XXX	1.26	1.51	1.20	1.51

Harvard Data:

	Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
92018									
	CMD	1.51	1.51	1.20	1.00	1.00	1.00	0.88	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
92018									
	CMD	XXX	1.26	t			33	t	

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
92018										
	CMD									

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
92018										
	CMD				0.88	1.51	op	3	0.038	

CMD Comments

06-Jul-95

Code: 92019

1995 RVUs: 1.31

Recommended RVUs: 0.38

Ratio: -0.71

Long Descriptor: Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 4,677 **Impact:** -4349.61

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
92019			
45910	DILATION OF RECTAL NARROWING	1.86	010
57400	DILATION OF VAGINA	0.83	000
57410	PELVIC EXAMINATION	0.59	000
99215	OFFICE/OUTPATIENT VISIT, EST	1.51	XXX

CMD Comment:

This is reduced by the same percentage as 92018.

Societies Wishing to Survey:

Societies Wishing to Comment: AAO, ACEP, AOA-HCPAC

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
92019	38.7	10.1	16	52.4	23.2	0	0	5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
92019	8224	5096	-21.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
92019	0.7	2	0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
92019		
	group practices	19.1
	ophthalmology	59.9
	other nonphysician prov	20.9

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

	ICD9	Pct of Time Used	ICD9 Descriptor
92019			
	318	6	OTHER SPECIFIED MENTAL RETARDATION
	344	3	OTHER PARALYTIC SYNDROMES
	362	3.3	OTHER RETINAL DISORDERS
	365	8.8	GLAUCOMA
	366	5.8	CATARACT
	372	4.3	DISORDERS OF CONJUNCTIVA
	377	3	DISORDERS OF OPTIC NERVE AND VISUAL PATHWAYS
	916	3	SUPERFICIAL INJURY OF HIP, THIGH, LEG, AND ANKLE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
92019							
CMD		XXX	XXX	1.02	1.31	1.28	1.31

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
92019								
CMD	1.31	1.31	1.28	1.00	1.00	1.00	0.38	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
92019								
CMD	XXX	1.02	t	.		24	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
92019									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
92019									
CMD				0.38	1.31	op	3	0.043	

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 92020 Global Period: XXX Current RVW: 0.37 Recommended RVW: 0.37

CPT Descriptor: Gonioscopy with medical diagnostic evaluation (separate procedure)

Source and Summary of Comment to HCFA on this service:

CMD Comments:

Recommended RVUs: 0.16

Reference Codes: 92081, 71020

Rationale for Change: CPT describes this as a separate procedure, but Medicare allows this to be billed with an eye exam. This is a unilateral exam compared to 92081 which is a bilateral exam. The interpretation is not as difficult and 71020.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A 53 year old hyperopic female with a family history of angle closure glaucoma was previously noted to have an intraocular pressure of 22. She returns for further diagnostic evaluation by gonioscopy."

Description of Pre-Service Work: The previous record and charts are reviewed.

Description of Intra-Service Work: The history of the patient's ocular hypertension is explained to her along with the familial incidence of angle closure glaucoma. The need to assess the status of the angle to determine whether it was open or closed is explained to the patient and the implications of that. She's also explained the nature of the procedure. At this point a drop of topical anesthetic is placed in the inferior cul-de-sac of each eye. The patient's head is placed in the slit lamp and the patient's given a fixation target to look at. The gonioscopy lens is carefully placed on the cornea. It is slowly rotated 360 degrees so that the angle can be viewed in its entirety. The lens is rotated on the patient's eye and the patient is occasionally asked to look in different directions of gaze with the lens on the eye to better facilitate the view of the angle. When the angle structures are narrow, compression is performed with the lens against the cornea to diagnostically push the iris away from the angle to see if they can be opened manually. The gonioscopy lens is then removed from the eye. The Goniosol solution is irrigated from the patient's eye and the patient is given topical drops for the subsequent irritation. The patient is then explained the nature of the findings and the symptoms of angle closure.

Description of Post-Service Work: Arrangement is made to see the patient in follow up in six months. Because of the familial nature of the problem, telephone calls are usually fielded within the first six months on the implications of angle closure in the patient.

SURVEY DATA:Specialty: American Academy of OphthalmologySample Size: 103 Response Rate (%): 34 Median RVW: 0.5525th Percentile RVW: 0.40 75th Percentile RVW: 0.87 Low: 0.20 High: 2.50Median Pre-Service Time: 5 Median Intra-Service Time: 1025th Percentile Intra-Svc Time: 5 75th Percentile Intra-Svc Time: 15 Low: 4 High: 20

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5</u>	_____
ICU:	_____	_____
Other Hospital:	_____	_____
Office:	_____	_____

SURVEY DATA:Specialty: American Optometric AssociationSample Size: 70 Response Rate (%): 47 Median RVW: 0.6025th Percentile RVW: 0.50 75th Percentile RVW: 0.80 Low: 0.35 High: 1.14Median Pre-Service Time: 5 Median Intra-Service Time: 1025th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 15 Low: 5 High: 25

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5</u>	_____
ICU:	_____	_____
Other Hospital:	_____	_____
Office:	_____	_____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	92081	Visual field (examination(s))	0.36
2)	71020	Chest x-ray	0.22
3)	99213	Office/outpatient visit, est	0.55

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The time involved in providing 92020 is almost the same as 99213 with .55 RVW. Unlike 71020 with .22 RVW gonioscopy is an active, dynamic procedure with direct manipulation of the diagnostic lens on the patient's cornea under topical anesthesia which has the not uncommon iatrogenic risk of corneal abrasion. This involves more time and interpretation than the interpretation of a (71020). The interpretation of the viewed results during gonioscopy is as difficult as 71020 but requires direct patient to physician contact unlike 71020.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The time of 92020 is similar to 99213 with .55 RVW. The AAO feels that the CMDs' didn't understand the nature of gonioscopy or they would never have compared it to 71020. The interpretation involved in 92020 is a dynamic, real-time evaluation more analogous to fluoroscopic exams of the chest e.g. 71023 with .38 RVW. For these reasons the AAO recommends retention of the current value of .38 rather than the survey mean RVW of .55-.60 or the CMD recommendation of .16.

CMD Comments

06-Jul-95

Code: 92020 1995 RVUs: 0.37 Recommended RVUs: 0.16 Ratio: -0.57

Long Descriptor: Gonioscopy with medical diagnostic evaluation (separate procedure)

Reference Set (y/n): N Global Period: XXX Frequency: 580,818 Impact: -121971.78

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
92020			
71020	CHEST X-RAY	0.22	XXX
92081	VISUAL FIELD EXAMINATION(S)	0.36	XXX

CMD Comment:

CPT describes this as a separate procedure, but Medicare allows this to be billed with an eye exam. This is a unilateral exam compared to 92081 which is a bilateral exam. The interpretation is not as difficult as 71020.

Societies Wishing to Survey: AAO, AOA-HCPAC

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
92020	54.4	13.6	16.8	64.2	3.3	0.2	0.5	7.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
92020	611975	597062	-1.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
92020	0.4	0.1	-0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
92020		
	ophthalmology	91.8
	other nonphysician prov	7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
92020			
	362	6	OTHER RETINAL DISORDERS

CMD Comments

06-Jul-95

365	18	GLAUCOMA
366	8.5	CATARACT
379	2.6	OTHER DISORDERS OF EYE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
92020							
CMD		XXX	XXX	0.45	0.37	0.82	0.37

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
92020								
CMD	0.37	0.37	0.82	1.00	1.00	1.00	0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
92020								
CMD	XXX	0.45	t	.		16	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
92020									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
92020									
CMD				0.16	0.37	op	n	0.028	

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 92060 Global Period: XXX Current RVW: 0.50 Recommended RVW: 0.69

CPT Descriptor: Sensorimotor examination with multiple measurements of ocular deviation and medical diagnostic evaluation (eg, restrictive or paretic muscle with diplopia) (separate procedure)

Source and Summary of Comment to HCFA on this service:

CMD Comments:

Recommended RVUs: 0.23

Reference Codes: 94060, 72050

Rationale for Change: This is no different than what a neurologist does for the examination of any paretic muscle. CPT definition is that this is a separate procedure and Medicare pays for it along with any other exam.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "A 45 year old woman with known thyroid ophthalmopathy and diplopia has been stable for 18 months. She has vertical and horizontal separation of images unless she tilts her head back in an extreme manner. She is now seeking help for her diplopia."

Description of Pre-Service Work: Referral letters and medical records are reviewed.

Description of Intra-Service Work: The nature of the examination is explained to the patient including the possible risk of discomfort or conjunctival hemorrhage associated with forced duction and forced generation testing which may be necessary to perform. Verbal permission is obtained for these maneuvers. Ocular alignment is evaluated in nine positions of gaze for distance and in at least primary position and downgaze for near. Measurements of ocular alignment may be made either by alternate cover testing or a subjective sensory method (sometimes both will be required). Torsion is measured subjectively (double maddox rod test) and objectively (observation of fundus torsion). If the patient is unable to move an eye fully into a position of gaze, forced duction testing is completed (the eye is locally anesthetized and forceps are used to grasp the conjunctiva and attempt to rotate the eye into the position of gaze in question). If forced ductions do not suggest that restriction explains the problem, force generation testing is performed (the eye is grasped and the patient attempts to rotate the eye into the gaze position in question against the examiners resistance to assess the ability to generate force in that direction).

Description of Post-Service Work: The significance of the data obtained is discussed with the patient. Letters are dictated to other physicians involved in the patients care. Follow up visits, surgical dates, or other testing scheduled. The sensorimotor exam may be performed without forced duction or forced generation testing in some patients.

SURVEY DATA:Specialty: American Academy of OphthalmologySample Size: 103 Response Rate (%): 27 Median RVW: 1.4025th Percentile RVW: 1.05 75th Percentile RVW: 1.50 Low: 0.50 High: 2.00Median Pre-Service Time: 5 Median Intra-Service Time: 3025th Percentile Intra-Svc Time: 19.25 75th Percentile Intra-Svc Time: 40 Low: 10 High: 60

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5</u>	_____
ICU:	_____	_____
Other Hospital:	_____	_____
Office:	_____	_____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	94060	Evaluation of wheezing	0.31
2)	72050	X-ray exam of neck and spine	0.31
3)	99203	Office/Outpatient Visit New	1.14
4)	99214	Office/Outpatient Visit Established	0.94

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

See below.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Code 92060 is an extensive examination of the motor and sensory aspects of ocular motility. The descriptor requires multiple recorded measurements as well as physician supervision and interpretation of results (see new code descriptor). This is a separate stand-alone procedure. The Carrier Medical Directors suggested that this was no different than what a neurologist does for the examination of any paretic muscle. It would be an unusual neurologist who would perform such a lengthy procedure as part of their evaluation (see Attachment). Most neurologists and ophthalmologists might obtain such a set of measurements through consultation with an ocular motor specialist. While a neurologist may use a red glass and determine that the images deviate, 92060 is an actual quantified measurement in nine diagnostic positions of gaze both at distance and near, as a minimum. Further there is an evaluation of sensory function as part of 92060 that is not included in a neurological examination or the basic ocular motility, part of the ophthalmological exam codes, 92002 et. seq.

This sensorimotor examination has a median intra-service time of 30 minutes. There is also a pre-service and post-service time spent in preparation of patient materials and reports. The time of service is equivalent to that of 99203, (a level 3 E&M service) or slightly less than a Level 4 return visit (99214). The service, however, bears no relationship in scope and far exceeds the work found in 94060, the evaluation of simple wheezing, or that found in an x-ray of the neck and spine. The Harvard intra-service time for 94060 was 7 minutes and no time data was collected on 70250. There is far more physician face-to-face time with 92060.

The survey of the American Academy of Ophthalmology members found a 30 minute intra-service time and a median RVW recommended of 1.40. We believe that the appropriate RVW is at the least 1.14, matching that of CPT code 99203. We believe the Carrier Medical Directors made an error in their interpretation of the scope of this service and therefore greatly underestimated its value. Further, we believe this is a grossly undervalued code based on earlier extrapolated data where it may have not been considered a separate procedure.

The AAO upon further analysis during the presentation to the multi-disciplinary work group felt that the vignette was more complicated than the typical patient to whom the service was provided. This service was more commonly performed in the pediatric age group with strabismus. For this reason we agree with the multi-disciplinary work group rationale of decreasing the AAO RVW of 1.14 to 0.69. This represents the work involved in the original Harvard study.

CMD Comments

06-Jul-95

Code: 92060

1995 RVUs: 0.5

Recommended RVUs: 0.23

Ratio: -0.54

Long Descriptor: Sensorimotor examination with multiple measurements of ocular deviation and medical diagnostic evaluation (eg, restrictive or paretic muscle with diplopia) (separate procedure)

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 23,669 **Impact:** -6390.63

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
92060			
	72050 X-RAY EXAM OF NECK SPINE	0.31	XXX
	94060 EVALUATION OF WHEEZING	0.31	XXX

CMD Comment:

This is no different than what a neurologist does for the examination of any paretic muscle. CPT definition is that this is a separate procedure and Medicare pays for it along with any other exam.

Societies Wishing to Survey:

Societies Wishing to Comment: AAO, AOA-HCPAC

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
92060	52.6	13.2	8	52.6	6.6	0.2	0.7	3.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
92060	17694	22504	12.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
92060	3	0.7	-1.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
92060		
	neurology	6.3
	ophthalmology	75.1
	other nonphysician prov	15.5

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
92060		
362	3.4	OTHER RETINAL DISORDERS
365	3.4	GLAUCOMA
366	4.4	CATARACT
368	9.1	VISUAL DISTURBANCES
377	1.2	DISORDERS OF OPTIC NERVE AND VISUAL PATHWAYS
378	15.9	STRABISMUS AND OTHER DISORDERS OF BINOCULAR EYE MOVEMENTS
379	2.1	OTHER DISORDERS OF EYE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
92060							
CMD		XXX	XXX	0.69	0.50	0.72	0.50

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
92060								
CMD	0.50	0.50	0.72	1.00	1.00	1.00	0.23	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
92060								
CMD	XXX	0.69	t	.		22	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
92060									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
92060									
CMD				0.23	0.50	op	3	0.031	

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 92275 Global Period: XXX Current RVW: 1.01 Recommended RVW: 1.01

CPT Descriptor: Electroretinography, with medical diagnostic evaluation

Source and Summary of Comment to HCFA on this service:

CMD Comments:

Recommended RVUs: 0.40

Reference Codes: 99280

Rationale for Change: This test is very similar to visual evoked response except that the recording instrument is placed on the cornea.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: "The patient is an 18 year old Caucasian male with a history of night blindness for three years. An initial eye exam showed some abnormal pigment in the peripheral retina."

Description of Pre-Service Work: The referring letters are reviewed as well as copies of previous eye exams.

Description of Intra-Service Work: The patient's vision is measured at distance and near. The pupils are maximally dilated. The patient is dark-adapted for 30-45 minutes. Electroretinograms are then performed.

Topical anesthesia is applied, a reference electrode is placed on the forehead, and a contact lens electrode is placed on the anesthetized eye. The patient is seated in front of a full-field light source. Patients are tested with single flashes of blue, red, and white light, then white flickering light and then single flashes of white light on a white background. The test is performed on one eye and then the other. If the electroretinographic (ERG) responses are not detectable with conventional recording, computer-averaged ERG responses are obtained.

Electroretinograms are read taking into account the refractive error, pupil size, clarity of the ocular media, and age. Recordings are measured and checked both for their size and temporal aspects (time between stimulus and peak responses). The recordings are interpreted against standard norms and correlated with other functional tests, including the visual field, dark adaptation, and color vision tests.

Description of Post-Service Work: A clinical interpretation of the ERG findings is generated and recorded in the patient's medical record.

CPT Code: 92275

SURVEY DATA:

Specialty: American Academy of Ophthalmology

Sample Size: 33 Response Rate (%): 48 Median RVW: 1.47

25th Percentile RVW: 1.00 75th Percentile RVW: 1.75 Low: 0.55 High: 4.50

Median Pre-Service Time: 10 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 55 Low: 5 High: 120

Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>16</u>	<u> </u>
ICU:	<u> </u>	<u> </u>
Other Hospital:	<u> </u>	<u> </u>
Office:	<u> </u>	<u> </u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>Short Descriptor</u>	<u>RVW</u>
1)	92280	Special eye evaluation	0.35
2)	99203	Office/Outpatient Visit, new	1.14

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 92275 (ERGs) have very little in common with the reference service cited by the CMDs - 99280 (VERs). The pre, intra and post service time and intensity of 92275 are much similar to those of a level 3 new patient visit (99203). Code 99280 is an electrophysiologic test, however, it merely tests the conduction pathway from the eye to the brain and takes approximately a third of the time necessary to perform 92275. There is no Harvard data relating to the time involved to 99280; however, the Harvard data for 92275 compares very closely with the median intra-service time of 38 minutes obtained in this current survey. With regard to the time and effort involved, we feel very strongly that 92275 is more closely related to 99203.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Both the Harvard study and the current survey have concluded that this test requires approximately 34 to 38 minutes as the median intra-service time. There is approximately a 10-minute pre-service time required in addition. In contrast to the 99280, which does not require the patient to be dilated and does not require multiple tests, the 92275 requires that a patient have eye drops instilled and that the patient be dilated. Then the patient must spend approximately 30 minutes to dark adapt and then the patient is tested under various conditions. First the patient is tested in a dark adapted state with a blue light, a red light and a bright white flash. Each of these are done separately and independently, and results in a separate and independent tracing. Then the patient is allowed to light adapt for approximately 10 minutes and then another bright light flash is obtained, again, independently from the previous tracings. Then a flicker, white, a flicker red and a flicker blue are performed in the light adapted state, again each of which is a separate tracing in a separate test.

As far as the interpretation, the VER results in a single tracing. The ERG consists of multiple independent tracings each of which need to be evaluated separately and independently reported by the physician. The readings must take into account the patient's refractive error, pupil size, clarity of the ocular media and age; all of which require review of the patient's medical record or performing the test to obtain the measure. These recordings are interpreted against standard norms and correlated with other functional tests. The accuracy of such report is extremely important and may markedly affect the patient's outlook with regard to visual prognosis and genetic counselling.

Therefore, we suggest that the 1995 RVW of 1.01 be maintained.

CMD Comments

06-Jul-95

Code: 92275

1995 RVUs: 1.01

Recommended RVUs: 0.40

Ratio: -0.60

Long Descriptor: Electroretinography, with medical diagnostic evaluation

Reference Set (y/n): N Global Period: XXX Frequency: 4,978 Impact: -3036.58

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
92275			
	92280 SPECIAL EYE EVALUATION	0.35	XXX

CMD Comment:

This test is very similar to visual evoked response except that the recording instrument is placed on the cornea.

Societies Wishing to Survey: AAP, AOA-HCPAC

Societies Wishing to Comment: AAO

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
92275	49	9	9.9	62.1	10.3	0.7	1.4	2.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
92275	7548	5750	-12.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
92275	0.8	1	0.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
92275		
	neurology	4.3
	ophthalmology	89
	other nonphysician prov	2.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
92275			
	362	10.7	OTHER RETINAL DISORDERS
	365	2.1	GLAUCOMA

CMD Comments

06-Jul-95

366	6.9	CATARACT
368	2.9	VISUAL DISTURBANCES
371	2.6	CORNEAL OPACITY AND OTHER DISORDERS OF CORNEA
377	1.9	DISORDERS OF OPTIC NERVE AND VISUAL PATHWAYS
379	1.7	OTHER DISORDERS OF EYE
V80	3.1	SPECIAL SCREENING FOR NEUROLOGICAL, EYE, AND EAR DISEASES

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
92275							
AAOph		XXX	XXX	0.64	1.01	1.58	1.01
CMD		XXX	XXX	0.64	1.01	1.58	1.01

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
92275								
AAOph	1.01	1.01	1.58	1.00	1.00	1.00	INCR	459
CMD	1.01	1.01	1.58	1.00	1.00	1.00	0.40	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
92275								
AAOph	XXX	0.64	t	.		34	t	.
CMD	XXX	0.64	t	.		34	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
92275									
AAOph
CMD

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
92275									
AAOph				INCR	1.01	op	3	0.019	
CMD				0.40	1.01	op	3	0.019	

AMA/SPECIALTY SOCIETY

RVS UPDATE COMMITTEE

FIVE YEAR REVIEW

RUC Recommendations

Volume 3

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE YEAR REVIEW OF THE RBRVS
RECOMMENDATIONS

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American Medical Association

Physicians dedicated to the health of America



Grant V. Rodkey, MD
Chairman
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March 14, 1997

Grant Bagley, MD
Medical Officer, Bureau of Policy Development
Health Care Financing Administration
Room C5-14-04
7500 Security Boulevard
Baltimore, MD 21244

Dear Doctor Bagley:

As you know, a key issue addressed in the May 3, 1996 Notice of Proposed Rulemaking on the five-year review of the RBRVS was whether and how the increases in the relative work values for evaluation and management services should be incorporated into the work values for global services. In the November 22, 1996 Final Rule containing the 1997 Medicare RBRVS, the Health Care Financing Administration (HCFA) summarized the comment on this issue that was submitted by the American Medical Association/Specialty Society RVS Update Committee (RUC), responded to this comment, and indicated its final decision on this issue, as follows:

Comment: The RUC recommended that we include the relationship between evaluation and management services and global surgical services in a future review of work RVUs so that this aspect of the Medicare physician fee schedule can be updated in 1998. We plan to revisit this issue next year.

Response: We look forward to a RUC recommendation on this issue. We hope to receive the recommendation next year to assist us as we further examine whether a change in the work RVUs for global surgical services is warranted because of the increases in the RVUs for evaluation and management services.

Final Decision: With the exception of the services described above that have an MMM global period, at present we are making no adjustments to the work RVUs assigned to global surgical services as a result of the increases in the RVUs of evaluation and management services. However, we will reevaluate this policy next year. The extra year will allow time for us to closely examine our data and for the RUC to present us with additional data and a recommendation on this issue. Any further changes that we may make will be effective in 1998.

The RUC considered this issue at its September 1996 meeting and adopted the following recommendations from the Research Subcommittee:

1. There is an evaluation and management component of the global service package.
2. The subcommittee accepts Dr. Dunn's report for informational purposes.
3. The subcommittee recommends that the RUC adopt the principle that evaluation and management services have equivalent work value across all physician specialties.
4. The subcommittee recommends that the RUC request that HCFA adjust global service relative values to incorporate changes in the evaluation and management service relative values as published in the May 3, 1996 *Federal Register*.

The question of *how* the changes in the evaluation and management service relative values should be incorporated in the global service relative values was further addressed at the February 1997 RUC meeting. The attached report was prepared by Daniel Dunn, PhD, to reflect the RUC recommendations adopted at this meeting. Dr. Dunn's analysis is, therefore, based on the following assumptions:

- The increases in global service work should be calculated on a code-by-code basis for each code with a global period of 010 or 090.
- The work of postoperative hospital visits has increased in a similar way to that of other subsequent hospital visit services. The full 1997 increase in evaluation and management work for these CPT codes (99231, 99232, 99233, and 99238) should be incorporated into global service work relative values.
- The work of postoperative office visits has also increased. However, due to the nature of these services when performed following surgery, the full 1997 increase in evaluation and management service work for these CPT codes (99211, 99212, 99213, 99214, and 99215) should not be incorporated into global surgical work. Instead, the intrawork per unit time for postoperative office visits should be increased by 10% (consistent with HCFA's assumption for the evaluation and management codes), and pre- and postservice work for these services, as a percentage of intrawork, should be increased by 12% (rather than the 25% increase HCFA applied to the office visits).
- The most recent and accurate data should be used to determine the number and level of hospital and office visits included in global service work. Dr. Dunn's analysis includes data from both the Harvard and the RUC surveys. HCFA may wish to adjust these data if more recent data on numbers of visits or lengths of stay are available from other sources.

The RUC is unanimous in recommending that HCFA adopt these assumptions and the approach reflected in the attached analysis. The RUC understands, however, that the actual relative values in Dr. Dunn's report may be adjusted based on other data that may be available to HCFA. The attached report concludes that the recommended increases to global surgical evaluation and management work would result in payment increases of approximately 2% for many surgical subspecialties, while minimally impacting other specialties.

The overall Medicare Payment Schedule budgetary impact is estimated to be 0.6%. As you know, the other changes in physician work relative values resulting from the five-year review were made budget neutral for Medicare through use of a separate adjustment factor. This meant that the budget neutrality adjustment was not necessarily passed on to other public and private payers using the RBRVS. Likewise, the budgetary impact of this five-year review change should be addressed through use of a separate budget neutrality adjustment factor.

Thank you for your prompt consideration of this RUC recommendation. We understand that HCFA intends to address this issue in its Spring Proposed Rule and that there will be an additional opportunity for comment following publication of this Notice.

Sincerely,



Grant V. Rodkey, MD

cc: Kathleen Buto
Terry Kay

**Incorporating the 1997 Changes in Work RVUs for E&M
Services into the Work RVUs for Global Surgery**

Report to the American Medical Association/Specialty Society
Relative Value Update Committee (RUC)

Daniel L. Dunn, PhD
Integrated Healthcare Information Services, Inc.
February 28, 1997

*Incorporating the 1997 Changes in Work RVUs for E&M Services into the Work RVUs
for Global Surgery -- Report to the RUC*

Daniel L. Dunn, PhD, Integrated Healthcare Information Services, Inc.
February 28, 1997

Executive Summary

One area of debate surrounding the changes in work relative values units (RVUs) for the 1997 Medicare Fee Schedule (MFS) focused on the impact of increases in work RVUs for evaluation and management (E&M) services on global surgical work. In addition to the procedure itself, a global surgery includes the related pre- and post-operative visits a surgeon performs within a defined period of time. With the exception of selected maternity care and delivery services, HCFA decided to make no adjustment to global surgical work RVUs for the 1997 MFS as a result of increases in E&M service RVUs. Instead, HCFA proposed to undertake a more thorough review of this issue and reevaluate their decision for 1998, including obtaining further input from the American Medical Association/Specialty Society Relative Value Update Committee (RUC) and collecting additional data on the E&M components of global surgeries.

The study described in this report addressed four key components of the reevaluation of global surgical work. First, the study assembled a detailed database on the number and level of post-operative hospital and office visits for a large number of global surgeries. These data include the most recent estimates of these visits from the RUC and data from the Harvard RBRVS study. Second, the study proposed a methodology for incorporating changes in E&M service work into global surgical work. Third, new values for total work were computed for almost all global surgeries in the 1997 MFS. Finally, the impacts of changes in global surgical work on Medicare payments to individual services, categories of service and specialties were computed.

The study findings show that increases in global surgical work from incorporating changes in E&M service work would not be large, but they would be systematic. Typical changes in work RVUs for global surgeries range from 4 to 7 percent, depending on the global package definition for a service ('010' or '090'). Since practice and malpractice expense RVUs are held constant, the changes in total RVUs are approximately half of those found for work and average 2 to 4 percent. These changes are similar across different categories of surgical services.

A simulation of the effect of changes in global surgical work on Medicare specialty payments found again that the impacts are not large, but they are systematic. For surgical specialties, the overall impact on Medicare payments is an increase of 1.8 percent, while the impact on payments to all other specialties is negligible. The overall MFS budgetary impact of these changes is 0.6 percent.

*Incorporating the 1997 Changes in Work RVUs for E&M Services into the
Work RVUs for Global Surgery*

Report to the AMA/Specialty Society Relative Value Update Committee (RUC)

Daniel L. Dunn, PhD, Integrated Healthcare Information Services, Inc.
February 28, 1997

On November 22, 1996 the Health Care Financing Administration (HCFA) issued a rule finalizing the 1997 Medicare Fee Schedule (MFS) for physician and professional services. Included in this rule were revisions to the work relative value units (RVUs) for a large number of services resulting from the legislatively mandated 5-Year Review of the MFS. Among these revisions were systematic changes in the work values for evaluation and management (E&M) services. The work RVUs for the majority of the 98 visit and consultation services were increased -- by an average of 17 percent.

One area of debate surrounding the 1997 MFS focused on the impact of the changes in work RVUs for E&M services on global surgical work. In addition to the procedure itself, a global surgery includes the related pre- and post-operative activities a surgeon typically performs within a defined period of time. As specified in the Harvard RBRVS study which served as the basis for the initial MFS work values, these activities include patient hospital and office visits before and after the procedure. Work RVUs for these E&M services were incorporated explicitly by Harvard into the work RVUs for a global surgery.

With the exception of selected maternity care and delivery services, HCFA decided to make no adjustments for 1997 to global surgical work as a result of the increases in RVUs for E&M services. Instead, HCFA proposed to undertake a more thorough review of this issue and reevaluate their decision for 1998, including obtaining further input from the American Medical Association/Specialty Society Relative Value Update Committee (RUC) and collecting additional data on the E&M components of global surgical work.

Two important issues in the evaluation of global surgical work concern the availability of data on the post-operative hospital and office visits involved in performing a surgery and the potential impacts of incorporating changes in E&M service work into the work for individual global surgeries. The study described in this report addresses these two issues.

This study involved three major steps: (1) using data from the RUC and the Harvard RBRVS study, a database was constructed describing the post-operative hospital and office visits involved in performing a large number of global surgeries; (2) for each surgery, the impact of incorporating the 1997 changes in work RVUs for follow-up hospital and office visits was computed; and (3) estimates of the impacts of these changes on Medicare payments to individual services, categories of service, and specialties were computed.

I. Construction of a Post-Operative Visit Database for Global Surgical Services

Data required and data sources. In order to compute the impacts of incorporating the changes in E&M service work into global surgical work, data on the number, duration, and level of post-operative hospital and office visits for individual global surgeries were required. In particular, for each global surgery, an estimate of the number of these visits by E&M CPT code was needed. For follow-up visits in the hospital, this involved obtaining estimates of the number of these visits qualifying as CPT code 99231, 99232, 99233, and 99238. For office visits, the number of 99211, 99212, 99213, 99214, and 99215 visits were required. In this way, the increases in work RVUs for E&M service codes could be translated directly into increases in work for the post-operative visits making up each global surgery.

As specified by the RUC, this study focused only on those post-operative visits within the global period defined by the MFS. For hospital visits, these included ICU and other visits after the day of the procedure.

Study data were obtained from two sources: (1) information collected by the RUC and (2) information from the Harvard RBRVS study, as assembled by Dunn and Latimer for their investigation of practice expenses for the MFS¹. The RUC data were collected previously as part of the annual MFS update process for revisions to CPT and as part of the RUC's evaluation of services included in the 5-Year Review. This information included (in varying levels of completeness) the number, duration and level of post-operative hospital and office visits for more than 700 global surgeries. The Harvard data were collected during the various phases of the Harvard RBRVS Study and included the number and duration of post-operative visits for more than 3,000 global surgeries. A hierarchy was established by the RUC for the use of the Harvard and RUC data for this study. Where RUC data were available, these estimates were employed. For the remaining estimates, Harvard data, if available were used.

Determining the number of visits and average visit duration. For most global surgeries, the study data included the number and average duration of post-operative hospital and office visits. The Harvard data included these estimates for all global surgeries in that database. For the RUC data, these estimates were also available for most services. However, for some services, average length of hospital stay, rather than the number of hospital visits, was recorded. For other RUC services, the number of hospital or office visits was recorded without average visit duration. For the RUC data, where necessary, the number of post-operative hospital visits was estimated as the average length of stay recorded by the RUC minus 1.0 (since these visits represent visits after the day of the procedure). Further, where the RUC average visit duration was missing it was estimated using the average duration from the Harvard data for the same or a similar procedure.

¹ D.L. Dunn and E.Latimer, "Derivation of Relative Values for Practice Expenses Using Extant Data: Final Report to the Health Care Financing Administration," Harvard University, April, 1996.

Assigning visits to CPT levels. Post-operative visits were assigned to CPT levels using the visit durations recorded in the study database. This duration represents visit intra-service time and can be compared with the typical times included in the CPT guidelines for each E&M CPT code. For example, CPT states that for code 99231 the physician typically spends 15 minutes at the bedside and on the patient's hospital floor. Therefore, post-operative hospital visits in the database with a duration of 15 minutes or less were assigned a CPT code of 99231. Visits with average durations of approximately 25 and 35 minutes were similarly assigned to CPT codes 99232 and 99233, respectively. Where typical durations did not exactly fit into the CPT guidelines for a hospital visit, combinations of CPT codes were used. For example, three post-operative hospital visits totaling 55 minutes in intra-service time (average duration 18.3 minutes) were assigned two 99231s and one 99232.

CPT guidelines were also used to assign CPT codes to post-operative ICU visits. According to CPT, ICU visits with a total duration less than 30 minutes are to be coded using subsequent hospital visit CPT codes 99232 or 99233. ICU visits were assigned to these two codes using this approach. Although recorded separately in the study database, post-operative ICU visits were then treated in the same way as all other 99232 and 99233 visits for the analysis.

Finally, since a post-operative hospital stay involves a patient discharge service, for each global surgery involving a hospital stay, one of the hospital visits recorded was assigned to CPT code 99238 -- "Hospital discharge day management, 30 minutes or less."

For a large number of office visits, the RUC data included surveyed estimates of the number of visits, by CPT level -- i.e., the number of 99211's, 99212's, 99213's, etc.. Where available, these were employed. For all other services, visit levels were assigned using average visit duration and a method similar to that described above for hospital visits.

Non-global services. By definition, non-global surgical and other services exclude post-operative office and hospital visits. No visits were assigned to these services.

Database Summary. Table 1 summarizes the source of data for global surgical post-operative hospital and office visits for the study. As shown, the Harvard study is the source of data for the majority of the 4,901 services included in the study database (global and non-global surgeries). For a small number of services in the 1997 MFS, neither RUC or Harvard were available. These services are identified in Appendix Table A-1 and were excluded from further study analyses.

Table 2 provides examples of the study data for selected global surgeries.

II. Incorporating the 1997 Increases in E&M Service Work into Global Surgical Work.

The method used to incorporate E&M work changes into global surgical work was straightforward. First, the amount of increase in work RVUs for 1997 for each relevant E&M CPT code was computed. Second, for each global surgery, the number of visits assigned to each E&M code was multiplied by this increase. Third, the results were added across E&M codes to compute the increase in work for the global surgery. Finally, this additional work was added to the 1997 MFS total work for the global surgery to compute the "new" work RVUs.

Increases in Work RVUs for E&M Services. As reported in the May 3, 1996 Federal Register, HCFA increased the work RVUs for E&M services for 1997 based on two separate assumptions:

- the intra work per unit of time for E&M services, in general, was undervalued relative to other services and should be increased, by approximately 10 percent and
- pre and post E&M service work has changed since the original work RVUs were developed -- pre and post work as a percentage of intra work should be increased by 25 percent.

The RUC evaluated HCFA's assumptions in increasing E&M service work and assessed their relevance for changes in global surgical work. The RUC made the following recommendations:

- The work of post-operative hospital visits has changed in a similar way to that of other subsequent hospital visit services. The full 1997 increase in E&M service work for these CPT codes (99231, 99232, 99233, 99238) should be incorporated into global surgical work.
- The work of post-operative office visits has also increased. However, due to the nature of these services when performed following surgery, the full 1997 increase in E&M service work for these CPT codes (99211, 99212, 99213, 99214, 99215) should not be incorporated into global surgical work. Instead, the intra-service work per unit of time for post-operative office visits should be increased by 10 percent and pre and post service work for these services, as a percentage of intra work, should be increased by 12 percent.

The change in E&M service work for post-operative hospital visits is straightforward to compute and is simply the difference between the 1997 and 1996 work values for these services. To measure changes in the work of post-operative office visit services using the RUC's assumptions, three estimates are required for each relevant E&M CPT code:

- (a) intra-service time (IST);
- (b) 1997 intra-service work per unit time (IWPUT97); and
- (c) pre- and post-service work as a percentage of intra-service work -- assuming a 12 percent increase over 1996 levels (PPW_IW12%).

To compute new work values for post-operative office visits, the following formula is then used:

$$\text{New Office Visit Total Work} = (\text{IST} * \text{IWPUT97}) * (1 + \text{PPW_IW12}\%).$$

The difference between this new work value and the 1996 work RVUs provides the change in post-operative office visit work to be used in this study.

Table 3 shows the change in work RVUs for each of the E&M CPT codes relevant for the study and the assumptions used in their computation.

Computing New Work Values for Global Surgical Services. An example may help to further illustrate the method used to compute global surgical work:

For global surgical CPT Code XXX:

Total Work, 1997 MFS	15.00
Post-op Hospital Visits	2 X 99231; 1X 99232; 1X 99238
Post-op Office Visits	3 X 99213
1997 increase in work for 99231	0.09 per visit
1997 increase in work for 99232	0.18 per visit
1997 increase in work for 99238	0.22 per visit
1997 assumed increase in work for 99213	0.10 per visit

New work for Code XXX is:

$$15.88 = 15.00 + (2 \text{ X } .09) + (1 \text{ X } .18) + (1 \text{ X } .22) + (3 \text{ X } .10).$$

RVUs from the 1997 MFS and the visit data from the study database were used for all of these computations.

III. Impacts of Changes in Global Surgical Work RVUs on Individual Services, Categories of Service, and Specialty Payments.

Individual services. Table 4 provides examples of RVUs for the 1997 MFS and values computed using the method described above. As shown, the increases in RVUs for most individual surgeries are not large, but they are systematic.

Table 5 summarizes the changes in global surgical work, by global package. Global surgeries fall into the '010' (10 day post-op period), '090' (90-day post-op period) and 'MMM' (maternity and delivery) global package categories. Only the results for services with physician work are included in this summary. The change in work is expressed as the ratio of new work to 1997 MFS work.

As expected, no change is shown for non-global services. As described above, these services include no post-operative office and hospital visits after the day of the procedure.

Further, little change is shown for 'MMM' services. Since HCFA incorporated changes in E&M service work into almost all of these maternity services for the 1997 MFS, no additional work was added to these amounts.

For the '010' globals, the mean and median increases are 4 and 3 percent, respectively. Almost all increases for these services are between 1 and 9 percent (as expressed by the values for the 5th and 95th percentiles).

The '090' globals show a somewhat larger change. The mean and median increases for these services are 7 percent. Most increases are between 3 and 13 percent.

Table 6 presents the same type of results as in Table 5, except for total rather than work RVUs. Since practice and malpractice expense RVUs are held constant, the changes in total RVUs are approximately half of those shown for work and average 2 to 4 percent.

Tables 7 and 8 present changes in work and total RVUs, respectively, by category of service, as defined by ranges of CPT codes. As shown, the mean and median changes are quite similar across surgical categories of service.

Table 9 provides a summary of a simulation of the impacts on Medicare specialty payments. These impacts were measured using a national summary of 1995 Medicare Part B claims, by CPT, modifier, and specialty. All services in the 1997 MFS (with non-zero total RVUs) with available data were included in the simulation. These include all non-global services and global surgeries for which both study data and 1995 Part B data were available. Study data on global visits were unavailable for approximately 280 of the global surgeries defined in the 1997 MFS. Part B data were unavailable for a small number of global surgeries which are new CPT codes since 1995.

As shown in Table 9, the impacts on Medicare specialty payments are not large but are again systematic, depending on specialty-type. For surgical specialties, the impacts vary from 0.7 percent for otolaryngology to 2.6 percent for cardiac surgery, general surgery, plastic surgery, surgical oncology, thoracic surgery and vascular surgery. The impacts on payments to all other specialties are negligible, with the exception of dermatology which would experience a 0.6 percent increase in payments.

Table 9 also summarizes the total impacts on Medicare payments, by specialty-type (see "Sub-Total" amounts). For surgical specialties as a group, payments would increase by 1.8 percent. No measurable impact is observed for all other specialty-types.

Finally, the effect on total Medicare payments to all specialties would also be small. The overall MFS budgetary impact is estimated to be 0.6 percent. (See the "Total" amounts at the bottom of Table 9.) If the changes in work were implemented in a budget neutral fashion, all specialty impacts reported here would be adjusted downward by 0.6 percent.

IV. Comments

This study addressed four key components of the reevaluation of including 1997 changes in E&M work into global surgical work. First, the study assembled a detailed database on the number and level of post-operative hospital and office visits for a large number of global surgeries. These data include the most recent estimates from the RUC and data from the Harvard RBRVS study. Second, the study proposed a methodology for incorporating changes in E&M service work into global surgical work. Third, new values for total work were computed for almost all global surgeries in the 1997 MFS. Finally, the impacts of changes in global surgical work on Medicare payments to individual services, categories of service and specialties were computed. The data, methods and results of this study provide a useful approach for reassessing the incorporation of the new E&M service work values into global surgical work for the 1998 MFS.

Some comments regarding the data and methods used in the study are warranted. First, data on post-operative visits were unavailable for approximately 280 global surgeries in the 1997 MFS (see Appendix Table A-1.). A strategy is required for deriving estimates for these services.

Second, visit estimates from two different sources were combined to produce the study database. Although these data represent the most current estimates available for the purposes of the study, the methods used to collect data for the two sources and the time period during which they were collected may vary. As a result, some inconsistencies and rank order anomalies for selected services may exist. Further review of the study database and the new work values produced using these data may be warranted for selected services.

Finally, the study employed a number of assumptions in constructing estimates of the number and level of post-operative visits and incorporating changes in work for these visits into global surgical work. Although these assumptions are supported by extensive data and research on physician's work and the MFS, they may warrant further discussion and review before their use in constructing final work RVUs for the 1998 MFS.

Table 1. Source of Study Data on Post-Operative Visits

Source	Hospital Visits		Office Visits	
	Number	Percent	Number	Percent
RUC	664	13.5	719	14.7
Harvard	2972	60.6	2913	59.4
Non-Global	994	20.3	994	20.3
Missing	271	5.5	275	5.6
Total	4901	100	4901	100

Note: the study database is restricted to global and non-global surgical services included in the MFS.

Table 2. Pre- and Post-Operative Visit Database for Global Surgical Services
Examples for Selected Codes

CPT	Pack Description	Source of Data		Number of Visits in Hospital						Number of Office Visits					
		HospVis	OffVis	Total	99231	99232	99233	99238	ICU32	ICU33	Total	99211	99212	99213	99214	99215
10060	010 Drainage of skin abscess	harv	harv	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0
11043	010 Debride tissue/muscle	ruc	ruc	2.0	1.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0	2.0	0.0
15572	090 Form skin pedicle flap	ruc	ruc	2.0	1.0	0.0	0.0	1.0	0.0	0.0	3.0	0.0	1.0	0.0	2.0
17010	010 Destruction skin lesion(s)	harv	harv	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0
19240	090 Removal of breast	harv	harv	5.0	4.0	0.0	0.0	1.0	0.0	0.0	5.5	0.0	0.0	5.5	0.0
20805	090 Replant forearm, complete	ruc	ruc	7.0	6.0	0.0	0.0	1.0	0.0	0.0	7.0	0.0	3.0	3.0	1.0
25628	090 Repair wrist bone fracture	ruc	ruc	1.0	0.0	0.0	0.0	1.0	0.0	0.0	4.0	0.0	0.0	4.0	0.0
27134	090 Revise hip joint replacement	ruc	ruc	8.0	6.0	0.0	0.0	1.0	1.0	0.0	3.0	0.0	0.0	2.0	1.0
29881	090 Knee arthroscopy/surgery	harv	harv	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.0	0.0	0.0	3.0	0.0
33504	090 Coronary artery graft	ruc	ruc	8.0	4.5	0.0	0.0	1.0	2.5	0.0	2.0	0.0	0.0	1.0	1.0
33512	090 CABG, vein, three	harv	harv	11.0	8.0	0.0	0.0	1.0	2.0	0.0	1.5	0.0	0.0	0.0	1.5
35301	090 Rechanneling of artery	ruc	ruc	4.0	1.0	0.0	0.0	1.0	2.0	0.0	2.0	0.0	0.0	2.0	0.0
44140	090 Partial removal of colon	ruc	ruc	7.0	5.0	1.0	0.0	1.0	0.0	0.0	3.0	0.0	1.0	0.0	2.0
44950	090 Appendectomy	ruc	ruc	2.0	1.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	2.0	0.0	0.0
49505	090 Repair inguinal hernia	harv	harv	1.0	0.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	2.0	0.0	0.0
52601	090 Prostatectomy (TURP)	harv	harv	4.0	3.0	0.0	0.0	1.0	0.0	0.0	2.5	0.0	0.0	2.5	0.0
56307	010 Laparoscopy; remove adnexa	ruc	ruc	1.0	0.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	1.0	1.0	0.0
58150	090 Total hysterectomy	ruc	ruc	5.0	4.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0	2.0	0.0
58260	090 Vaginal hysterectomy	harv	harv	4.0	3.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0	2.0	0.0
61312	090 Open skull for drainage	ruc	ruc	15.0	8.0	0.0	0.0	1.0	6.0	0.0	4.0	0.0	0.0	4.0	0.0
63030	090 Low back disk surgery	ruc	ruc	4.0	3.0	0.0	0.0	1.0	0.0	0.0	3.0	0.0	1.0	1.0	1.0
66984	090 Remove cataract, insert lens	harv	ruc	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0	0.0	1.0	2.0	1.0
66985	090 Insert lens prosthesis	harv	harv	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	0.0	0.0	5.0	0.0

Note: ICU32 and ICU33 indicate post-operative ICU visits. According to CPT, ICU visits with a total duration less than 30 minutes are to be coded using subsequent hospital visit CPT codes 99232 or 99233. These visits were coded using this approach when constructing the study data. ICU32 and ICU33 indicate ICU visits coded as 99232 and 99233, respectively.

Table 3. Work Relative Value Units for Established Patient Office and Subsequent Hospital Visits
Assumptions used to Increase RVUs for Global Surgical Visits

CPT	Intra Time	1996 Work RVUs	1997 Intra-Service Work Per Unit Time	Study Assumption for Pre-Post Work as a % of Intra Work	Study 1997 Work RVUs	Difference from 1996 Work RVUs
99211	5	0.17	0.031	39.3%	0.17	0.00
99212	10	0.38	0.031	39.3	0.43	0.05
99213	15	0.55	0.031	39.3	0.65	0.10
99214	25	0.94	0.031	39.3	1.08	0.14
99215	40	1.51	0.031	39.3	1.73	0.22
99231	15	0.51	-	-	0.64	0.13
99232	25	0.88	-	-	1.06	0.18
99233	35	1.25	-	-	1.51	0.26
99238	30	1.06	-	-	1.28	0.22

Note: Work RVUs for each global surgery were adjusted based on the number of post-operative visits assigned to each E&M CPT code and the incremental increase in the work RVUs for that code (amount in column: Difference from 1996 Work RVUs). The full 1997 increase in work RVUs for subsequent hospital visits was used in the study. For post-operative office visits, 1996 intra-service work per unit of time was increased by 10 percent (from 0.028 to 0.031) and 1996 pre- and post-service work as a percent of intra-service work was increased by 12 percent (from 35.1 to 39.3). No change in work RVUs was employed for CPT code 99211.

**Table 4. Incorporating Changes in E&M Service Work into Global Surgical Work
Computed RVUs for Selected Codes**

CPT	Pack	Description	1997 MFS RVUs		New RVUs	
			Work	Total	Work	Total
10060	010	Drainage of skin abscess	1.12	1.60	1.17	1.65
11043	010	Debride tissue/muscle	1.83	3.98	2.38	4.53
15572	090	Form skin pedicle flap	8.59	15.83	9.27	16.51
17010	010	Destruction skin lesion(s)	1.01	1.53	1.06	1.58
19240	090	Removal of breast	14.71	26.14	16.00	27.43
20805	090	Replant forearm, complete	48.41	102.14	50.00	103.73
25628	090	Repair wrist bone fracture	7.81	16.10	8.43	16.72
27134	090	Revise hip joint replacement	27.00	64.37	28.52	65.89
29881	090	Knee arthroscopy/surgery	7.46	18.82	7.76	19.12
33504	090	Coronary artery graft	23.16	57.91	24.66	59.41
33512	090	CABG, vein, three	27.84	69.39	29.67	71.22
35301	090	Rechanneling of artery	17.79	35.06	18.70	35.97
44140	090	Partial removal of colon	16.97	30.74	18.35	32.12
44950	090	Appendectomy	8.25	14.15	8.70	14.60
49505	090	Repair inguinal hernia	6.17	11.62	6.49	11.94
52601	090	Prostatectomy (TURP)	11.51	24.54	12.37	25.40
56307	010	Laparoscopy; remove adnexa	10.68	19.44	11.05	19.81
58150	090	Total hysterectomy	14.30	25.95	15.24	26.89
58260	090	Vaginal hysterectomy	11.39	22.85	12.20	23.66
61312	090	Open skull for drainage	21.83	50.42	24.57	53.16
63030	090	Low back disk surgery	11.10	29.41	12.00	30.31
66984	090	Remove cataract, insert lens	9.89	23.49	10.28	23.88
66985	090	Insert lens prosthesis	7.89	18.62	8.39	19.12

**Table 5. Incorporating 1997 Changes in MFS RVUs for E&M Services into the
 Work RVUs for Global Surgeries
 Distribution of Change in Work RVUs**

Ratio of Scenario Work RVUs to 1997 Work RVUs
 (Includes only services with work RVUs in the 1997 MFS and sufficient study data)

Global Package	Number of Services	Ratio			
		Mean	Median	5th%	95th%
010	412	1.04	1.03	1.01	1.09
090	3192	1.07	1.07	1.03	1.13
MMM	18	1.01	1.00	1.00	1.24
NonGobal	2839	1.00	1.00	1.00	1.00

**Table 6. Incorporating 1997 Changes in MFS RVUs for E&M Services into the
 Work RVUs for Global Surgeries
 Distribution of Change in Total RVUs**

Ratio of New Total RVUs to 1997 Work RVUs
 (Includes only services with work RVUs in the 1997 MFS and sufficient study data)

Global Package	Number of Services	Ratio			
		Mean	Median	5th%	95th%
010	412	1.02	1.02	1.00	1.05
090	3192	1.04	1.03	1.02	1.07
MMM	18	1.01	1.00	1.00	1.13
NonGobal	2839	1.00	1.00	1.00	1.00

Table 7. Incorporating 1997 Changes in MFS RVUs for E&M Services into the Work RVUs for Global Surgeries

Distribution of Change in Work RVUs, by Category of Service
 Ratio of New Work RVUs to 1997 MFS Work RVUs
 (Includes only 1997 MFS services with work RVUs)

Category of Service	Glob Pack	No. of Services	Mean	Median	5th%	95th%
AUDITORY	010	12	1.03	1.03	1.00	1.04
AUDITORY	090	65	1.04	1.03	1.02	1.06
AUDITORY	NGL	10	1.00	1.00	1.00	1.00
CARDIOVASCULAR	010	9	1.01	1.00	1.00	1.06
CARDIOVASCULAR	090	362	1.08	1.08	1.04	1.14
CARDIOVASCULAR	NGL	105	1.00	1.00	1.00	1.00
DIGESTIVE	010	67	1.04	1.03	1.01	1.10
DIGESTIVE	090	438	1.09	1.09	1.04	1.15
DIGESTIVE	NGL	143	1.00	1.00	1.00	1.00
GYNECOLOGY	010	36	1.03	1.03	1.01	1.05
GYNECOLOGY	090	86	1.08	1.07	1.04	1.12
GYNECOLOGY	NGL	33	1.00	1.00	1.00	1.00
INTEGUMENTARY	010	129	1.03	1.02	1.01	1.07
INTEGUMENTARY	090	134	1.08	1.07	1.04	1.13
INTEGUMENTARY	NGL	87	1.00	1.00	1.00	1.00
MUSCULOSKELETAL	010	54	1.05	1.03	1.01	1.14
MUSCULOSKELETAL	090	1141	1.07	1.06	1.03	1.12
MUSCULOSKELETAL	NGL	105	1.00	1.00	1.00	1.00
NEUROSURGERY	010	19	1.03	1.02	1.00	1.12
NEUROSURGERY	090	320	1.07	1.07	1.04	1.12
NEUROSURGERY	NGL	94	1.00	1.00	1.00	1.00
OPHTHALMOLOGY	010	31	1.05	1.03	1.01	1.07
OPHTHALMOLOGY	090	187	1.05	1.05	1.02	1.08
OPHTHALMOLOGY	NGL	25	1.00	1.00	1.00	1.00
RESPIRATORY	010	17	1.05	1.04	1.02	1.07
RESPIRATORY	090	149	1.09	1.07	1.03	1.17
RESPIRATORY	NGL	89	1.00	1.00	1.00	1.00
URINARY	010	31	1.04	1.03	1.01	1.13
URINARY	090	241	1.07	1.07	1.04	1.12
URINARY	NGL	132	1.00	1.00	1.00	1.00
EVAL&MNGMT	NGL	102	1.00	1.00	1.00	1.00
OTHER MEDICINE	NGL	471	1.00	1.00	1.00	1.00
PATHOLOGY AND LAB	NGL	118	1.00	1.00	1.00	1.00
RADIOLOGY	NGL	1113	1.00	1.00	1.00	1.00

Table 8. Incorporating 1997 Changes in MFS RVUs for E&M Services into the Work RVUs for Global Surgeries

Distribution of Change in Total RVUs, by Category of Service
 Ratio of New Total RVUs to 1997 MFS Work RVUs
 (Includes only 1997 MFS services with work RVUs)

Category of Service	Glob Pack	No. of Services	Mean	Median	5th%	95th%
AUDITORY	010	12	1.02	1.02	1.00	1.03
AUDITORY	090	65	1.02	1.02	1.01	1.03
AUDITORY	NGL	10	1.00	1.00	1.00	1.00
CARDIOVASCULAR	010	9	1.01	1.00	1.00	1.04
CARDIOVASCULAR	090	362	1.04	1.04	1.02	1.07
CARDIOVASCULAR	NGL	105	1.00	1.00	1.00	1.00
DIGESTIVE	010	67	1.02	1.02	1.00	1.05
DIGESTIVE	090	438	1.05	1.05	1.02	1.08
DIGESTIVE	NGL	143	1.00	1.00	1.00	1.00
GYNECOLOGY	010	36	1.02	1.01	1.00	1.03
GYNECOLOGY	090	86	1.04	1.04	1.03	1.06
GYNECOLOGY	NGL	33	1.00	1.00	1.00	1.00
INTEGUMENTARY	010	129	1.02	1.01	1.00	1.04
INTEGUMENTARY	090	134	1.04	1.04	1.02	1.07
INTEGUMENTARY	NGL	87	1.00	1.00	1.00	1.00
MUSCULOSKELETAL	010	54	1.03	1.02	1.01	1.08
MUSCULOSKELETAL	090	1141	1.03	1.03	1.02	1.06
MUSCULOSKELETAL	NGL	105	1.00	1.00	1.00	1.00
NEUROSURGERY	010	19	1.02	1.01	1.00	1.08
NEUROSURGERY	090	320	1.03	1.03	1.02	1.06
NEUROSURGERY	NGL	94	1.00	1.00	1.00	1.00
OPHTHALMOLOGY	010	31	1.03	1.02	1.01	1.04
OPHTHALMOLOGY	090	187	1.02	1.02	1.01	1.04
OPHTHALMOLOGY	NGL	25	1.00	1.00	1.00	1.00
RESPIRATORY	010	17	1.03	1.03	1.01	1.04
RESPIRATORY	090	149	1.04	1.04	1.02	1.08
RESPIRATORY	NGL	89	1.00	1.00	1.00	1.00
URINARY	010	31	1.03	1.02	1.01	1.07
URINARY	090	241	1.04	1.04	1.02	1.06
URINARY	NGL	132	1.00	1.00	1.00	1.00
EVAL&MNGMT	NGL	102	1.00	1.00	1.00	1.00
OTHER MEDICINE	NGL	471	1.00	1.00	1.00	1.00
PATHOLOGY AND LAB	NGL	118	1.00	1.00	1.00	1.00
RADIOLOGY	NGL	1113	1.00	1.00	1.00	1.00

Notes for Tables 7 and 8

NGL = Non-Global Services

Definition of Type of Service Groupings -- Ranges of CPT Codes

'10000' - '19499' = 'INTEGUMENTARY'
'20000' - '29909' = 'MUSCULOSKELETAL'
'30000' - '32999' = 'RESPIRATORY'
'33000' - '37799' = 'CARDIOVASCULAR'
'38000' - '38999' = 'LYMPHATIC'
'39000' - '49999' , '56315' - '56349' ,
'56360' - '56399' = 'DIGESTIVE'
'50000' -- '56299' = 'URINARY'
'56300' - '56314' , '56350' - '56356' ,
'56400' - '58999' = 'GYNECOLOGY'
'59000' - '59899' = 'MATERNITY'
'60000' - '60699' = 'ENDOCRINOLOGY'
'61000' - '64999' = 'NEUROSURGERY'
'65000' - '68899' = 'OPHTHALMOLOGY'
'69000' - '69999' = 'AUDITORY'
'70010' - '79999' = 'RADIOLOGY'
'80002' - '89399' = 'PATHOLOGY AND LAB'
'90000' - '90699' , '92000' - '92014' ,
'90700' - '90799' = 'IMMUNIZ/CHEMOTHER'
'90801' - '90915' = 'MENTAL HEALTH'
'90916' - '91999' , '92015' - '92974' , '92997' - '93500' ,
'93661' - '99099' , '99141' - '99199' = 'OTHER MEDICINE'
'92975' - '92996' , '93501' - '93660' = 'INVASIVE CARDIOLOGY'
'99216' - '99380' , '99431' - '99499' ,
'99201' - '99215' , '99381' - '99429' = 'EVAL & MNMNT'

Table 9. Incorporating 1997 Changes in E&M Service RVUs into
Global Surgical Work
Simulated Impacts on Medicare Specialty Payments

Specialty	<u>1995 Medicare Allowed Charges</u>		
	No Change in Global Surgical Work RVUs	Incorporating 1997 E&M Work Changes	Ratio of Change to "No Change"
Surgical Specialties			
Cardiac Surg	\$ 179,592,335	\$ 184,311,063	1.026
Gen Surgery	1,992,598,357	2,043,950,691	1.026
Hand Surgery	27,161,165	27,699,786	1.020
Maxillof Srg	5,468,646	5,563,001	1.017
Neurosurgery	345,221,149	352,296,310	1.020
Ob-Gyn	307,522,911	311,986,812	1.015
Ophthalmolgy	3,945,630,367	3,996,629,658	1.013
Oral Surgery	13,140,183	13,319,773	1.014
Ortho Surgry	1,924,885,840	1,971,711,939	1.024
Otolarynglgy	487,449,955	490,620,297	1.007
Periph Vasc	22,056,683	22,482,087	1.019
Plastic Surg	205,230,675	210,493,977	1.026
Podiatry	637,335,589	643,362,556	1.009
Proctology	81,228,538	82,745,093	1.019
Surg Oncology	25,155,609	25,820,140	1.026
Thoracic Srg	481,195,817	493,947,045	1.026
Urology	1,172,108,359	1,184,513,458	1.011
Vascular Srg	263,688,949	270,541,697	1.026
Sub-Total	12,116,671,127	12,331,995,383	1.018
Medical and Other Specialties			
Allergy	93,179,997	93,197,113	1.000
Cardiology	3,343,699,249	3,346,925,378	1.001
Crit Care	60,318,817	60,371,388	1.001
Dermatology	955,904,797	961,412,852	1.006
Emergency Med	725,749,873	726,468,415	1.001
Endocrinolgy	146,937,568	146,944,216	1.000
Family Prac	2,362,623,924	2,363,953,288	1.001
Gastroentrlg	1,149,714,363	1,149,999,559	1.000
Gen Int Med	5,105,770,357	5,106,643,089	1.000
Gen Practice	1,061,258,207	1,062,396,148	1.001

Table 9. Incorporating 1997 Changes in E&M Service RVUs into
Global Surgical Work
Simulated Impacts on Medicare Specialty Payments

Specialty	1995 Medicare Allowed Charges		
	No Change in Global Surgical Work RVUs	Incorporating 1997 E&M Work Changes	Ratio of Change to "No Change"
<i>Medical and Other Specialties (continued)</i>			
Geriatrics	\$ 72,833,956	\$ 72,842,890	1.000
Hem/Onc	465,142,418	465,190,560	1.000
Infect Dis	176,194,028	176,220,763	1.000
Medical Onc	135,274,650	135,288,701	1.000
Nephrology	672,315,361	672,384,685	1.000
Neurology	609,863,133	610,081,245	1.000
Neuropsych	9,716,338	9,717,739	1.000
Optometrist	243,221,092	243,260,322	1.000
Pediatrics	36,699,066	36,728,456	1.001
Prev Med	1,960,883	1,961,583	1.000
Psychiatry	948,955,728	948,962,971	1.000
Psychologist	933,327	933,327	1.000
Pulmonry Dis	863,440,444	863,473,166	1.000
Rheumatology	202,892,787	202,907,068	1.000
Clinic	1,279,777,159	1,284,995,088	1.004
Other	1,545,708,082	1,549,620,736	1.003
Sub-Total	22,270,085,604	22,292,880,747	1.001
<i>Anesthesiology, Radiology, and Pathology</i>			
Anesthesiology	1,281,859,790	1,282,149,781	1.000
CRNA	284,059,936	284,063,049	1.000
Iv Radiology	113,292,734	113,600,539	1.003
Nuclear Med	54,088,352	54,103,180	1.000
Pathology	524,945,444	524,956,188	1.000
Rad Oncology	473,507,858	473,522,228	1.000
Radiology	2,526,977,207	2,528,717,491	1.001
Sub-Total	5,258,731,321	5,261,112,456	1.000
<i>All Specialties</i>			
Total	39,645,488,052	39,885,988,585	1.006

Incorporating the 1997 Changes in Work RVUs for E&M Services into the Work RVUs for Global Surgery. Report to the RUC. Daniel L. Dunn, PhD, February 28, 1997

Appendix Table A-1: Global Surgical Services in the 1997 MFS
with Insufficient Data for Inclusion in the Study

CPT STATUS	GLOB	DESC	WRKRVU	TTLRVU
77762 A	090	Radioelement application	5.35	11.75
77762 A	090	Radioelement application	5.35	8.09
77763 A	090	Radioelement application	8.01	16.64
77763 A	090	Radioelement application	8.01	12.09
77777 A	090	Radioelement application	6.99	14.87
7777726A	090	Radioelement application	6.99	10.57
77778 A	090	Radioelement application	10.46	21.02
7777826A	090	Radioelement application	10.46	15.82
77781 A	090	High intensity brachytherapy	1.55	22.91
7778126A	090	High intensity brachytherapy	1.55	2.35
77782 A	090	High intensity brachytherapy	2.33	24.10
7778226A	090	High intensity brachytherapy	2.33	3.54
77783 A	090	High intensity brachytherapy	3.49	25.83
7778326A	090	High intensity brachytherapy	3.49	5.27
77784 A	090	High intensity brachytherapy	5.24	28.49
7778426A	090	High intensity brachytherapy	5.24	7.93
77789 A	090	Radioelement application	1.05	2.04
7778926A	090	Radioelement application	1.05	1.58
92986 A	090	Revision of aortic valve	20.34	33.28
92990 A	090	Revision of pulmonary valve	16.22	26.52
G0051 A	010	Destroy benign/premal lesion	0.55	1.00

Appendix Table A-1. Global Surgical Services in the 1997 MFS
with Insufficient Data for Inclusion in the Study

CPT STATUS	GLOB	DESC	WRKRVU	TTLRVU	
43360	A	090	Gastrointestinal repair	26.06	51.61
43361	A	090	Gastrointestinal repair	29.67	59.71
47511	A	090	Insert bile duct drain	9.91	13.03
48001	A	090	Placement of drain, pancreas	15.54	25.56
48005	A	090	Resect/debride pancreas	17.57	28.90
48146	A	090	Pancreatectomy	21.73	40.14
48154	A	090	Pancreatectomy	36.50	63.79
48556	A	090	Removal, allograft pancreas	13.89	22.84
49021	A	090	Drain abdominal abscess	9.06	14.79
49507	A	090	Repair, inguinal hernia	7.40	13.52
50727	A	090	Revise ureter	7.57	13.45
50728	A	090	Revise ureter	11.13	19.80
50782	A	090	Reimplant ureter in bladder	18.23	33.47
50783	A	090	Reimplant ureter in bladder	19.17	34.41
52450	A	090	Incision of prostate	7.05	12.53
54401	A	090	Insert self-contd prosthesis	9.67	23.78
56322	A	090	Laparoscopy, vagus nerves	9.70	15.95
56323	A	090	Laparoscopy, vagus nerves	11.65	19.15
56324	A	090	Laparoscopy, cholecystoenter	11.90	22.99
56342	A	090	Laparoscopic cholecystectomy	13.86	25.23
56631	A	090	Extensive vulva surgery	14.57	37.78
56634	A	090	Extensive vulva surgery	16.25	41.97
56637	A	090	Extensive vulva surgery	20.34	46.27
56810	A	010	Repair of perineum	3.97	7.10
58262	A	090	Vaginal hysterectomy	13.06	24.52
58263	A	090	Vaginal hysterectomy	14.27	26.81
58345	A	010	Reopen fallopian tube	4.61	8.51
58825	A	090	Transposition, ovary(s)	5.63	10.59
60271	A	090	Removal of thyroid	14.16	28.55
61760	A	090	Implant brain electrodes	21.00	37.73
62281	A	010	Treat spinal cord lesion	2.61	3.76
64612	A	010	Destroy nerve, face muscle	1.91	3.53
64613	A	010	Destroy nerve, spine muscle	1.91	3.53
64716	A	090	Revision of cranial nerve	5.80	11.30
64755	A	090	Incision of stomach nerves	13.10	25.84
64885	A	090	Nerve graft, head or neck	16.73	30.90
64886	A	090	Nerve graft, head or neck	19.95	36.85
65860	A	090	Incise inner eye adhesions	3.37	8.05
66700	A	090	Destruction, ciliary body	4.55	10.73
66710	A	090	Destruction, ciliary body	4.55	10.79
66740	A	090	Destruction, ciliary body	4.55	10.77
67414	A	090	Explore/decompress eye socke	10.07	18.90
67445	A	090	Explore/decompress eye socke	13.36	25.06
67570	A	090	Decompress optic nerve	12.52	20.47
68761	A	010	Close tear duct opening	1.31	2.27
77750	A	090	Infuse radioactive materials	4.59	8.29
77750	A	090	Infuse radioactive materials	4.59	6.94
77761	A	090	Radioelement application	3.56	7.93
77761	A	090	Radioelement application	3.56	5.38

Appendix Table A-1. Global Surgical Services in the 1997 MFS
with Insufficient Data for Inclusion in the Study

CPT	STATUS	GLOB	DESC	WRKRVU	TTLRVU
29851	A	090	Knee arthroscopy/surgery	12.38	25.07
29855	A	090	Tibial arthroscopy/surgery	9.48	23.05
29856	A	090	Tibial arthroscopy/surgery	13.28	26.85
30460	A	090	Revision of nose	9.48	18.99
30462	A	090	Revision of nose	18.98	38.01
30801	A	010	Cauterization inner nose	1.02	1.54
30802	A	010	Cauterization inner nose	1.98	3.03
33501	A	090	Repair heart vessel fistula	16.14	32.79
33517	A	090	CABG, artery-vein, single	2.27	5.66
33518	A	090	CABG, artery-vein, two	4.55	11.34
33519	A	090	CABG, artery-vein, three	6.82	16.99
33521	A	090	CABG, artery-vein, four	9.10	22.67
33522	A	090	CABG, artery-vein, five	11.37	28.34
33523	A	090	CABG, artery-vein, six+	13.65	34.02
33533	A	090	CABG, arterial, single	24.00	59.81
33534	A	090	CABG, arterial, two	26.99	67.26
33535	A	090	CABG, arterial, three	29.98	74.71
33536	A	090	CABG, arterial, four+	32.96	82.15
33800	A	090	Aortic suspension	15.18	31.83
34151	A	090	Removal of artery clot	15.23	29.58
35691	A	090	Arterial transposition	16.70	40.13
35693	A	090	Arterial transposition	14.01	25.32
35695	A	090	Arterial transposition	17.81	29.31
36834	A	090	Repair A-V aneurysm	9.32	18.78
40800	A	010	Drainage of mouth lesion	1.12	1.93
40801	A	010	Drainage of mouth lesion	2.48	4.34
40804	A	010	Removal foreign body, mouth	1.19	1.83
40805	A	010	Removal foreign body, mouth	2.64	5.44
40808	A	010	Biopsy of mouth lesion	0.91	1.75
40810	A	010	Excision of mouth lesion	1.26	2.55
40812	A	010	Excise/repair mouth lesion	2.26	3.90
40814	A	090	Excise/repair mouth lesion	3.27	6.82
40816	A	090	Excision of mouth lesion	3.52	7.07
40818	A	090	Excise oral mucosa for graft	2.26	4.71
40819	A	090	Excise lip or cheek fold	2.26	3.63
40820	A	010	Treatment of mouth lesion	1.23	1.82
40830	A	010	Repair mouth laceration	1.71	2.45
40831	A	010	Repair mouth laceration	2.41	4.56
41800	A	010	Drainage of gum lesion	1.12	1.88
41805	A	010	Removal foreign body, gum	1.19	2.11
41806	A	010	Removal foreign body, jawbone	2.64	4.43
41822	R	010	Excision of gum lesion	2.26	5.54
41823	R	090	Excision of gum lesion	3.75	7.69
41825	A	010	Excision of gum lesion	1.12	2.89
41826	A	010	Excision of gum lesion	2.26	4.51
41827	A	090	Excision of gum lesion	3.27	7.43
41828	R	010	Excision of gum lesion	3.04	7.44
41830	R	010	Removal of gum tissue	3.30	8.07
41872	R	090	Repair gum	2.44	5.97
41874	R	090	Repair tooth socket	2.94	7.19

Appendix Table A-1. Global Surgical Services in the 1997 MFS
with Insufficient Data for Inclusion in the Study

CPT	STATUS	GLOB	DESC	WRKRVU	TTLRVU
21485	A	090	Reset dislocated jaw	3.73	6.12
21490	A	090	Repair dislocated jaw	11.08	17.91
21493	A	090	Treat hyoid bone fracture	1.19	2.84
21494	A	090	Repair hyoid bone fracture	5.87	14.02
21495	A	090	Repair hyoid bone fracture	5.32	10.65
21497	A	090	Interdental wiring	3.61	7.96
21740	A	090	Reconstruction of sternum	15.42	26.05
21750	A	090	Repair of sternum separation	10.07	18.83
23616	A	090	Repair humerus fracture	19.88	45.74
24006	A	090	Release elbow joint	8.70	17.01
24516	A	090	Repair humerus fracture	10.92	22.11
24546	A	090	Repair humerus fracture	14.66	26.22
25520	-A	090	Repair fracture of radius	6.01	12.69
25525	A	090	Repair fracture of radius	11.69	24.67
25526	A	090	Repair fracture of radius	12.43	26.22
25574	A	090	Treat fracture radius & ulna	6.03	15.48
26546	A	090	Repair non-union hand	8.50	17.94
26608	A	090	Treat metacarpal fracture	5.12	9.24
27193	A	090	Treat pelvic ring fracture	4.64	7.44
27194	A	090	Treat pelvic ring fracture	8.73	13.13
27215	A	090	Pelvic fracture(s) treatment	9.39	23.74
27216	A	090	Treat pelvic ring fracture	14.20	19.16
27217	A	090	Treat pelvic ring fracture	13.19	30.07
27218	A	090	Treat pelvic ring fracture	18.83	35.71
27226	A	090	Treat hip wall fracture	13.93	32.23
27245	A	090	Repair of thigh fracture	18.72	37.64
27496	A	090	Decompression of thigh/knee	4.75	10.02
27497	A	090	Decompression of thigh/knee	5.81	12.27
27498	A	090	Decompression of thigh/knee	6.63	13.99
27499	A	090	Decompression of thigh/knee	7.64	16.11
27501	A	090	Treatment of thigh fracture	5.29	11.52
27503	A	090	Treatment of thigh fracture	9.51	18.39
27507	A	090	Treatment of thigh fracture	12.85	31.43
27509	A	090	Treatment of thigh fracture	6.77	11.64
27511	A	090	Treatment of thigh fracture	12.50	31.06
27535	A	090	Treatment of knee fracture	10.36	23.93
27558	A	090	Repair of knee dislocation	16.75	33.78
27759	A	090	Repair of tibia fracture	12.60	28.56
27824	A	090	Treat lower leg fracture	2.71	6.73
27825	A	090	Treat lower leg fracture	5.08	12.65
27826	A	090	Treat lower leg fracture	7.43	18.81
27829	A	090	Treat lower leg joint	4.87	12.47
27892	A	090	Decompression of leg	6.03	10.06
27893	A	090	Decompression of leg	5.99	10.04
28531	A	090	Treat sesamoid bone fracture	2.01	4.24
28576	A	090	Treat foot dislocation	3.75	6.94
29800	A	090	Jaw arthroscopy/surgery	5.28	9.75
29804	A	090	Jaw arthroscopy/surgery	7.99	19.68
29850	A	090	Knee arthroscopy/surgery	7.96	19.89

Appendix Table A-1. Global Surgical Services in the 1997 MFS
with Insufficient Data for Inclusion in the Study

CPT STATUS	GLOB	DESC	WRKRVU	TTLRVU
21270	A	090 Augmentation cheek bone	9.56	20.57
21275	A	090 Revision orbitofacial bones	10.50	20.71
21280	A	090 Revision of eyelid	5.64	13.44
21282	A	090 Revision of eyelid	3.26	8.57
21295	A	090 Revision of jaw muscle/bone	1.43	2.52
21296	A	090 Revision of jaw muscle/bone	3.97	7.81
21325	A	090 Repair of nose fracture	3.52	8.13
21330	A	090 Repair of nose fracture	5.03	12.34
21335	A	090 Repair of nose fracture	8.05	19.92
21336	A	090 Repair nasal septal fracture	5.35	9.96
21337	A	090 Repair nasal septal fracture	2.52	5.72
21338	A	090 Repair nasaoethmoid fracture	6.04	11.71
21339	A	090 Repair nasaoethmoid fracture	7.56	15.35
21340	A	090 Repair of nose fracture	10.07	20.02
21343	A	090 Repair of sinus fracture	12.10	22.35
21344	A	090 Repair of sinus fracture	18.43	28.68
21345	A	090 Repair of nose/jaw fracture	7.63	16.34
21346	A	090 Repair of nose/jaw fracture	9.92	20.36
21347	A	090 Repair of nose/jaw fracture	11.86	23.58
21348	A	090 Repair of nose/jaw fracture	15.60	29.16
21360	A	090 Repair cheek bone fracture	6.04	14.21
21366	A	090 Repair cheek bone fracture	16.61	31.05
21385	A	090 Repair eye socket fracture	8.56	19.28
21386	A	090 Repair eye socket fracture	8.56	18.88
21387	A	090 Repair eye socket fracture	9.07	17.48
21390	A	090 Repair eye socket fracture	9.47	22.73
21395	A	090 Repair eye socket fracture	11.85	22.85
21400	A	090 Treat eye socket fracture	1.31	3.15
21401	A	090 Repair eye socket fracture	3.05	5.95
21406	A	090 Repair eye socket fracture	6.55	12.50
21407	A	090 Repair eye socket fracture	8.05	15.92
21408	A	090 Repair eye socket fracture	11.57	21.05
21421	A	090 Treat mouth roof fracture	4.80	11.56
21422	A	090 Repair mouth roof fracture	7.78	18.77
21423	A	090 Repair mouth roof fracture	9.72	20.71
21431	A	090 Treat craniofacial fracture	6.59	13.32
21432	A	090 Repair craniofacial fracture	8.05	15.65
21433	A	090 Repair craniofacial fracture	23.69	43.75
21435	A	090 Repair craniofacial fracture	16.12	31.25
21436	A	090 Repair craniofacial fracture	26.21	42.94
21440	A	090 Repair dental ridge fracture	2.52	5.87
21445	A	090 Repair dental ridge fracture	5.03	11.70
21450	A	090 Treat lower jaw fracture	2.78	5.88
21451	A	090 Treat lower jaw fracture	4.55	11.12
21452	A	090 Treat lower jaw fracture	1.85	3.41
21453	A	090 Treat lower jaw fracture	5.18	12.37
21454	A	090 Treat lower jaw fracture	6.04	15.65
21461	A	090 Repair lower jaw fracture	7.56	18.53
21462	A	090 Repair lower jaw fracture	9.15	22.20
21465	A	090 Repair lower jaw fracture	11.13	20.56

Appendix Table A-1. Global Surgical Services in the 1997 MFS
with Insufficient Data for Inclusion in the Study

CPT STATUS	GLOB DESC	WRKRUV	TTLRVU
19020 A	090 Incision of breast lesion	3.37	5.05
19316 A	090 Suspension of breast	10.07	25.34
19357 A	090 Breast reconstruction	16.72	31.24
19361 A	090 Breast reconstruction	17.82	41.83
19366 A	090 Breast reconstruction	19.84	39.42
20962 A	090 Other bone graft, microvasc	37.00	69.16
21010 A	090 Incision of jaw joint	9.06	20.23
21015 A	090 Resection of facial tumor	4.94	12.39
21026 A	090 Excision of facial bone(s)	4.53	7.95
21029 A	090 Contour of face bone lesion	7.21	17.22
21030 A	090 Removal of face bone lesion	6.04	9.68
21032 A	090 Remove exostosis, maxilla	3.14	7.37
21034 A	090 Removal of face bone lesion	15.11	22.98
21040 A	090 Removal of jaw bone lesion	2.01	5.01
21044 A	090 Removal of jaw bone lesion	11.08	21.74
21045 A	090 Extensive jaw surgery	15.11	30.52
21050 A	090 Removal of jaw joint	10.07	23.48
21060 A	090 Remove jaw joint cartilage	9.56	22.19
21070 A	090 Remove coronoid process	7.66	15.29
21077 A	090 Prepare face/oral prosthesis	31.54	77.11
21079 A	090 Prepare face/oral prosthesis	20.88	51.06
21080 A	090 Prepare face/oral prosthesis	23.46	57.36
21081 A	090 Prepare face/oral prosthesis	21.38	52.27
21082 A	090 Prepare face/oral prosthesis	19.50	47.68
21083 A	090 Prepare face/oral prosthesis	18.04	44.11
21084 A	090 Prepare face/oral prosthesis	21.04	51.46
21086 A	090 Prepare face/oral prosthesis	23.29	56.95
21087 A	090 Prepare face/oral prosthesis	23.29	56.95
21100 A	090 Maxillofacial fixation	4.04	5.21
21110 A	090 Interdental fixation	5.03	11.02
21141 A	090 Reconstruct midface, lefort	16.92	32.94
21142 A	090 Reconstruct midface, lefort	17.58	34.16
21143 A	090 Reconstruct midface, lefort	18.30	35.51
21208 A	090 Augmentation of facial bones	9.56	21.89
21209 A	090 Reduction of facial bones	6.28	11.63
21210 A	090 Face bone graft	9.56	23.09
21215 A	090 Lower jaw bone graft	10.07	24.38
21230 A	090 Rib cartilage graft	10.07	22.13
21235 A	090 Ear cartilage graft	6.28	15.41
21242 A	090 Reconstruction of jaw joint	12.10	29.90
21244 A	090 Reconstruction of lower jaw	11.08	27.19
21245 A	090 Reconstruction of jaw	11.08	23.86
21246 A	090 Reconstruction of jaw	11.65	21.52
21247 A	090 Reconstruct lower jaw bone	21.15	50.50
21255 A	090 Reconstruct lower jaw bone	15.63	37.31
21256 A	090 Reconstruction of orbit	15.13	36.12
21260 A	090 Revise eye sockets	15.44	36.86
21261 A	090 Revise eye sockets	29.43	48.86
21263 A	090 Revise eye sockets	26.56	63.42
21267 A	090 Revise eye sockets	17.66	34.40
21268 A	090 Revise eye sockets	22.88	41.36

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Imaging

The RUC considered public comments submitted by the American College of Radiology (ACR), the American College of Cardiology (ACC), and the Society of Cardiovascular and Interventional Radiology (SCVIR). In a public comment letter submitted to HCFA, ACR cited nine radiology codes that it believes are misvalued. The ACR noted that a multi-disciplinary approach was used to identify these nine procedures. Specifically, radiologists in each specialty of radiology were asked to review the procedures they perform and determine whether or not the RVU reflected the procedure. The selected procedures were then reviewed by a multi-disciplinary panel of radiologists and the ACR Commission on Economics. These nine procedures were determined to have an adequate case for reconsideration of their relative values.

Most of the codes reviewed in this section were reviewed because of comments from the CMDs. The CMDs stated that; "a large number of the suggested revisions are based upon a general overvaluation of plain film studies relative to more complex radiographic studies, ultrasound studies, and the most common CT and MRI studies. The relevant reference procedures are 70450 (revised upward), 70551, 70420, 74280, 74400, 75650, 76700, and 78605. The values listed below largely reflect differences in time and need for supervision, as well as slightly less intensity in interpretation. These services also appear markedly overvalued relative to the Evaluation and Management services which involve broader cognitive skills and much more time. For example, the equivalence of a level 3, 15 minute established patient visit to reading 2.5 chest x-rays (70210) has no face validity. A visit may involve the review of two or three radiographic studies as less than half of the work of the visit." The CMDs also presented the following three basic rationales for the changes that they suggested. 1) Simple planar contrast S&I procedures, such as aortography, have been decreased to equate the readings of these films with that of noncontrast films of the same parts. The presence of contrast medium makes it easier to read. The technical difficulties of injection are included in the associated surgical procedure. 2) MRIs should be revalued to reflect the fact that the work involved in interpreting MRIs is sufficiently comparable across various anatomic locations, that the same values should be assigned regardless of location. The interpretation of an MRI with contrast should not have a higher RVU since the work of interpreting may be easier rather than more difficult. 3) CT scans should be revalued to reflect the fact that the work involved in interpreting CT scans is sufficiently comparable across various anatomic locations, that the same values should be assigned regardless of location. The interpretation of an CT scan with contrast should not have a higher RVU since the work of interpreting may be easier rather than more difficult.

ACR Public Comments

As part of their report outlining the relative value recommendations to the RUC, ACR prepared an comprehensive rebuttal of the CMD comments. Specifically, ACR noted that: 1) The current physician work relative values (RVUs) for plain film studies accurately reflect the work involved in the procedure and, therefore, should be maintained. Contrary to the CMDs comments, plain film studies require physician involvement and, ACR survey data supports that the interpretation time

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of plain film studies requires more time than the evaluation and management code 99212 to which those studies were most often compared. 2) The current RVUs for contrast material should be retained since they reflect physician work. When contrast is used, physicians must interpret more images which increases their work. 3) Time data and intensity analysis prepared by ACR confirm the fact that the current values for CT scans reflect the physician work involved. The ACR also noted that the number of images varies by the site that is being imaged during a CT scan, which rebuts the CMD notion that the RVUs for CT scan be the same regardless of site. 4) ACR reported that the presence of contrast material increases the physician work of an MRI since the physician can visualize more anatomy.

The complete ACR report is attached. The RUC believes that extensive compelling evidence was presented by the specialty society and supports maintaining the current RVUs. These are presented in Table 1.

Table 2 contains the recommendations that were made by the specialty societies that were not covered by the ACR report. The RUC agreed with all of the recommended changes based on evidence that was presented by the ACR. For the codes that were presented by SCVIR, although the RUC agreed that the services were undervalued, they did not believe that SCVIR presented compelling evidence for the increases that they requested. Instead, the RUC adopted an increased RVU, but lower than the specialty recommended.

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TABLE 1

Code	Descriptor	95 RVU	RUC Rec RVU	Key
70030	X-ray eye for foreign body	0.17	0.17	2
70100	X-ray exam of jaw	0.18	0.18	2
70110	X-ray exam of jaw	0.25	0.25	2
70120	X-ray exam of mastoids	0.18	0.18	2
70130	X-ray exam of mastoids	0.34	0.34	2
70140	X-ray exam of facial bones	0.19	0.19	2
70150	X-ray exam of facial bones	0.26	0.26	2
70160	X-ray exam of nasal bones	0.17	0.17	2
70170	X-ray exam of tear duct	0.30	0.30	2
70210	X-ray exam of sinuses	0.17	0.17	2
70220	X-ray exam of sinuses	0.25	0.25	2
70250	X-ray exam of skull	0.24	0.24	2
70260	X-ray exam of skull	0.34	0.34	2
70300	X-ray exam of teeth	0.10	0.10	2
70310	X-ray exam of teeth	0.16	0.16	2
70320	Full mouth x-ray of teeth	0.22	0.22	2
70328	X-ray exam of jaw joint	0.18	0.18	2
70330	X-ray exam of jaw joints	0.24	0.24	2
70332	X-ray exam of jaw joint	0.54	0.54	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Key
70350	X-ray head for orthodontia	0.17	0.17	2
70355	Panoramic x-ray of jaws	0.20	0.20	2
70360	X-ray exam of neck	0.17	0.17	2
70380	X-ray exam of salivary gland	0.17	0.17	2
70390	X-ray exam of salivary duct	0.38	0.38	2
70450	CAT scan of head or brain	0.85	0.85	2
70460	Contrast CAT scan of head	1.13	1.13	2
70470	Contrast CAT scans of head	1.27	1.27	2
70480	CAT scan of skull	1.28	1.28	2
70481	Contrast CAT scan of skull	1.38	1.38	2
70482	Contrast CAT scans of skull	1.45	1.45	2
70486	CAT scan of face, jaw	1.14	1.14	2
70487	Contrast CAT scan, face/jaw	1.30	1.30	2
70488	Contrast CAT scans face/jaw	1.42	1.42	2
70490	CAT scan of neck tissue	1.28	1.28	2
70491	Contrast CAT of neck tissue	1.38	1.38	2
70492	Contrast CAT of neck tissue	1.45	1.45	2
70540	Magnetic image, face, neck	1.48	1.48	2
70551	Magnetic image, brain (MRI)	1.48	1.48	2
70552	Magnetic image, brain (MRI)	1.78	1.78	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Key
70553	Magnetic image, brain	2.36	2.36	2
71010	Chest x-ray	0.18	0.18	2
71015	X-ray exam of chest	0.21	0.21	2
71020	Chest x-ray	0.22	0.22	2
71021	Chest x-ray	0.27	0.27	2
71022	Chest x-ray	0.31	0.31	2
71035	Chest x-ray	0.18	0.18	2
71040	Contrast x-ray of bronchi	0.58	0.58	2
71060	Contrast x-ray of bronchi	0.74	0.74	2
71100	X-ray exam of ribs	0.22	0.22	2
71101	X-ray exam of ribs, chest	0.27	0.27	2
71110	X-ray exam of ribs	0.27	0.27	2
71111	X-ray exam of ribs, chest	0.32	0.32	2
71120	X-ray exam of breastbone	0.20	0.20	2
71130	X-ray exam of breastbone	0.22	0.22	2
71250	Cat scan of chest	1.16	1.16	2
71260	Contrast CAT scan of chest	1.24	1.24	2
71270	Contrast CAT scans of chest	1.38	1.38	2
71550	Magnetic image, chest	1.60	1.60	2
72020	X-ray exam of spine	0.15	0.15	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Key
72040	X-ray exam of neck spine	0.22	0.22	2
72050	X-ray exam of neck spine	0.31	0.31	2
72069	X-ray exam of trunk spine	0.22	0.22	2
72070	X-ray exam of thorax spine	0.22	0.22	2
72072	X-ray exam of thoracic spine	0.22	0.22	2
72074	X-ray exam of thoracic spine	0.22	0.22	2
72080	X-ray exam of trunk spine	0.22	0.22	2
72090	X-ray exam of trunk spine	0.28	0.28	2
72100	X-ray exam of lower spine	0.22	0.22	2
72110	X-ray exam of lower spine	0.31	0.31	2
72114	X-ray exam of lower spine	0.36	0.36	2
72120	X-ray exam of lower spine	0.22	0.22	2
72125	CAT scan of neck spine	1.16	1.16	2
72126	Contrast CAT scan of neck	1.22	1.22	2
72127	Contrast CAT scans of neck	1.27	1.27	2
72128	CAT scan of thorax spine	1.16	1.16	2
72129	Contrast CAT scan of thorax	1.22	1.22	2
72130	Contrast CAT scans of thorax	1.27	1.27	2
72131	CAT scan of lower spine	1.16	1.16	2
72132	Contrast CAT of lower spine	1.22	1.22	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Key
72133	Contrast CAT scans,low spine	1.27	1.27	2
72141	Magnetic image, neck spine	1.60	1.60	2
72142	Magnetic image, neck spine	1.92	1.92	2
72146	Magnetic image, chest spine	1.60	1.60	2
72147	Magnetic image, chest spine	1.92	1.92	2
72148	Magnetic image, lumbar spine	1.48	1.48	2
72149	Magnetic image, lumbar spine	1.78	1.78	2
72156	Magnetic image, neck spine	2.57	2.57	2
72157	Magnetic image, chest spine	2.57	2.57	2
72158	Magnetic image, lumbar spine	2.36	2.36	2
72170	X-ray exam of pelvis	0.17	0.17	2
72190	X-ray exam of pelvis	0.21	0.21	2
72192	CAT scan of pelvis	1.09	1.09	2
72193	Contrast CAT scan of pelvis	1.16	1.16	2
72194	Contrast CAT scans of pelvis	1.22	1.22	2
72196	Magnetic image, pelvis	1.60	1.60	2
72200	X-ray exam sacroiliac joints	0.17	0.17	2
72202	X-ray exam sacroiliac joints	0.19	0.19	2
72220	X-ray exam of tailbone	0.17	0.17	2
72265	Contrast x-ray lower spine	0.83	0.83	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Key
73000	X-ray exam of collarbone	0.16	0.16	2
73010	X-ray exam of shoulder blade	0.17	0.17	2
73020	X-ray exam of shoulder	0.15	0.15	2
73030	X-ray exam of shoulder	0.18	0.18	2
73040	Contrast x-ray of shoulder	0.54	0.54	2
73050	X-ray exam of shoulders	0.20	0.20	2
73060	X-ray exam of humerus	0.17	0.17	2
73070	X-ray exam of elbow	0.15	0.15	2
73080	X-ray exam of elbow	0.17	0.17	2
73085	Contrast x-ray of elbow	0.54	0.54	2
73090	X-ray exam of forearm	0.16	0.16	2
73092	X-ray exam of arm, infant	0.16	0.16	2
73100	X-ray exam of wrist	0.16	0.16	2
73110	X-ray exam of wrist	0.17	0.17	2
73115	Contrast x-ray of wrist	0.54	0.54	2
73120	X-ray exam of hand	0.16	0.16	2
73130	X-ray exam of hand	0.17	0.17	2
73140	X-ray exam of finger(s)	0.13	0.13	2
73200	CAT scan of arm	1.09	1.09	2
73201	Contrast CAT scan of arm	1.16	1.16	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Key
73202	Contrast CAT scans of arm	1.22	1.22	2
73220	Magnetic image, arm, hand	1.48	1.48	2
73225	Magnetic imaging/upper (MRA)	1.73	1.73	2
73500	X-ray exam of hip	0.17	0.17	2
73510	X-ray exam of hip	0.21	0.21	2
73520	X-ray exam of hips	0.26	0.26	2
73525	Contrast x-ray of hip	0.54	0.54	2
73530	X-ray exam of hip	0.29	0.29	2
73540	X-ray exam of pelvis & hips	0.20	0.20	2
73550	X-ray exam of thigh	0.17	0.17	2
73560	X-ray exam of knee	0.17	0.17	2
73562	X-ray exam of knee	0.18	0.18	2
73564	X-ray exam of knee	0.22	0.22	2
73565	X-ray exam of knee	0.17	0.17	2
73580	Contrast x-ray of knee joint	0.54	0.54	2
73590	X-ray exam of lower leg	0.17	0.17	2
73592	X-ray exam of leg, infant	0.16	0.16	2
73600	X-ray exam of ankle	0.16	0.16	2
73610	X-ray exam of ankle	0.17	0.17	2
73615	Contrast x-ray of ankle	0.54	0.54	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Key
73620	X-ray exam of foot	0.16	0.16	2
73630	X-ray exam of foot	0.17	0.17	2
73650	X-ray exam of heel	0.16	0.16	2
73660	X-ray exam of toe(s)	0.13	0.13	2
73700	CAT scan of leg	1.09	1.09	2
73701	Contrast CAT scan of leg	1.16	1.16	2
73702	Contrast CAT scans of leg	1.22	1.22	2
73720	Magnetic image, leg, foot	1.48	1.48	2
74000	X-ray exam of abdomen	0.18	0.18	2
74010	X-ray exam of abdomen	0.23	0.23	2
74020	X-ray exam of abdomen	0.27	0.27	2
74022	X-ray exam series, abdomen	0.32	0.32	2
74150	CAT scan of abdomen	1.19	1.19	2
74160	Contrast CAT scan of abdomen	1.27	1.27	2
74170	Contrast CAT scans, abdomen	1.40	1.40	2
74181	Magnetic image, abdomen (MRI	1.60	1.60	2
74710	X-ray measurement of pelvis	0.34	0.34	2
75552	Magnetic image, myocardium	1.60	1.60	2
75553	Magnetic image, myocardium	2.00	2.00	2
75554	Cardiac MRI/function	1.83	1.83	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Key
75555	Cardiac MRI/limited study	1.74	1.74	2
75556	Cardiac MRI/flow mapping	0.00	0.00	2
76066	Joint(s) survey, single film	0.31	0.31	2
76093	Magnetic image, breast	1.63	1.63	2
76094	Magnetic image, both breasts	1.63	1.63	2
76098	X-ray exam, breast specimen	0.16	0.16	2
76355	CAT scan for localization	1.21	1.21	2
76360	CAT scan for needle biopsy	1.16	1.16	2
76365	CAT scan for cyst aspiration	1.16	1.16	2
76370	CAT scan for therapy guide	0.85	0.85	2
76375	CAT scans, other planes	0.16	0.16	2
76380	CAT scan follow-up study	0.98	0.98	2
76400	Magnetic image, bone marrow	1.60	1.60	2
78075	Adrenal nuclear imaging	0.74	0.74	2
78635	CSF ventriculography	0.61	0.61	2

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TABLE 2

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
70336	Magnetic image jaw joint	0.95	1.48	The ACR believes that all of the joint MRI codes are undervalued.	ACR noted that MRI has new technology designed specifically for joint MRI, involving pulse sequences. The new pulse sequences add to the number of images the must be interpreted. ACR recommended an RVU of 1.48 which also represented their survey median. The RUC determined that compelling evidence was presented that this procedure is undervalued and recommends an increased RVU.	1
73221	Magnetic image, joint of arm	0.95	1.48			1
73721	Magnetic image, joint of leg	0.95	1.48			1
74330	X-ray,bile/pancreas endoscopy	0.70	0.90	The ACR believes that this code is undervalued.	ACR reported that during this procedure the radiologist must study and interpret images of both the biliary and pancreatic ducts. ACR also noted that therapeutic biliary procedures have been developed in the past five years, significantly increasing the time associated with this procedure. The RUC determined that compelling evidence was presented that this procedure is undervalued and recommends an increased RVU.	1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
75630	X-ray aorta, leg arteries	1.31	1.79	In their comments to HCFA, the specialty society noted that they believe that this code is undervalued relative to the amount of physician required to provide this service.	<p>SCVIR reported that it did not conduct a survey on this procedure. SCVIR did note this code describes the radiological supervision and interpretation of aortography and bilateral arteriograms. The radiologic S&I service described by this procedure involves the evaluation of the aorta and lower extremity arteries to the distal circulation. SCVIR noted that the S&I of an abdominal aortogram (75625) and S&I of for bilateral extremity arteriography (75716) are valued at 1.14 and 1.31 RVUs respectively. Therefore, since 75630[Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation] involves the work of both 75625 and 75716, SCVIR believes that the work of 75630 can be derived by adding the RVUs of 75625 and 75716 for an RVU of 2.45.</p> <p>The RUC agreed with the specialty society that this procedure is undervalued. However, they noted that although 75630 is a combination of 75625 and 75716, there is probably some overlap of the two procedures when they are part of 75630. Therefore, the RUC suggested a new RVU of 1.79 which is equal to: [75625] 1.14+(0.50)[75716] 1.31=1.79 or 1.14+(0.50)1.31=1.79</p>	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
76090	Mammogram, one breast	0.25	0.58	In their comments to HCFA, the specialty society noted that they believe that these codes are undervalued relative to the amount of physician required to provide these services.	In their presentation, the ACR noted that mammography has undergone the most significant change in the amount of physician work required during the past five years. They reported that at the time the work value was established for this procedure, there was no distinction between screening and diagnostic mammography. Patients now come in for diagnostic mammography for a problem detected in their breast, these patients are either referred by another physician or self referred. Also the patient usually expects to have some indication of her diagnosis before she leaves the mammography suite. ACR identified three major changes in mammography that have affected physician work. 1) In addition to the basic mammography views, supplemental views are also needed to evaluate significant abnormalities found on the basic views. 2) Radiologists face increased documentation requirements. 3) In the past, it was not standard for the radiologist to interact with the patient, this is expected today. The ACR recommended an RVU of 0.58 for 76090 and 0.69 for 76091 which represent the survey medians for both procedures. The RUC determined that compelling evidence was presented to increase the RVUs of these procedures.	1
76091	Mammogram, both breasts	0.41	0.69			1
76825	Echo exam of fetal heart	0.98	1.67	In their comments to HCFA, the specialty society noted that they believe that this code is undervalued relative to the amount of physician required to provide this service.	The ACC reported that the requirements for mental effort and clinical judgement in performing a fetal echocardiogram are significant. This exam requires a comprehensive knowledge of the forms of congenital heart disease and their morphology and associated malformations; and a complete understanding of fetal cardiocirculatory physiology. The physician must obtain enough views with enough visual clarity to avoid a false-positive diagnosis (with the possibility of termination of pregnancy) or a false negative result with the risk of missing a major cardiovascular malformation. The ACC recommended a value of 1.67 for this procedure. The RUC determined that compelling evidence was presented to warrant an increased RVU for this procedure.	1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
78070	Parathyroid nuclear imaging	0.51	0.82	The CMDs noted that 78070[Parathyroid imaging] is the equivalent of doing the two reference codes 78010[Thyroid imaging; only] and 78011[Thyroid imaging; with vascular flow] (since two different isotopes are used, two different procedures with similar pre-, intra-, and post-times are required).	<p>The ACR reported that the technique of this procedure has changed in the last five years. Physicians now, must spot smaller images in the parathyroid that are localized by radioisotopes, while at the same time correlating this information with other clinical data either from a previous surgery or some other imaging exam. The ACR felt that the work involved in this procedure is most similar to the key reference service 78018(0.95) - Thyroid carcinoma metastases; whole body. The ACR recommended an RVU of 0.95 for this procedure which is also the survey median.</p> <p>The RUC felt that this service was more comparable to 78015(.67) - thyroid carcinoma metastases imaging; limited area (eg, neck and chest only). The ACR noted that 78070 is a 2 phase study and noted that it is more difficult to spot parathyroid radioisotope images than thyroid metastases. The ACR did note however that 78070 is similar to 78016(0.82) - thyroid carcinoma metastases imaging; with additional studies (eg, urinary recovery). Based on this information, the RUC determined that 0.82 would be a more appropriate RVU for 78070.</p>	4

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it added to the five-year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
78195	Lymph system imaging	0.70	1.20	In their comments to HCFA, the specialty society noted that they believe that this code is undervalued relative to the amount of physician work required to provide this service.	<p>Although the ACR survey results indicate that nearly two-thirds of the respondents felt that the work involved in this procedure has not changed in the last five years, there ACR noted that there have been some changes to this procedure which have some bearing on the amount of physician work required to perform this test. Specifically, the procedure has benefitted from the development of small improved colloids, better imaging techniques, and the use of hand-held detectors to precisely localize sentinel nodes. Based on the results of this procedure, the patient can be spared extensive lymph node resection, treatment of lymphedema may be improved because of improved localization of lymph nodes at risk for tumor spread. Based on their survey median, the ACR recommended an RVU of 1.47 for this procedure. Nuclear physicians also provide this service and they reported that this service is performed infrequently and has become increasingly complex. The nuclear physicians also noted that because so few physicians provide this service, a survey would not be reflective of the physicians that provide this service.</p> <p>The RUC agreed that the work of this procedure has changed. However, given that it is performed infrequently by a handful of physicians, the RUC recommends an RVU of 1.20 for this procedure which reflects the 25th percentile of the survey.</p>	4
78805	Abcess imaging, ltd area	0.73	0.73	At the request of ACR, HCFA made technical corrections to CPT codes 78805 and 78806. ACR requests that these codes be removed from the five year review.	The RUC recommends maintaining the current values for these codes.	2
78806	Abcess imaging, whole body	0.73	0.73			2

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Key (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it added to the five-year review.

A Report on the Physician Work Relative Values for Radiology

A Presentation to the RUC Five Year Review
Workgroup on Radiology

Friday and Saturday
July 28th and 29th, 1995

Executive Summary

- The ACR's RVS was accepted by the Health Care Financing Administration (HCFA) without changes to the relative values.

The current relative values for radiology were derived by the ACR using a process similar to that used by Hsiao in the RBRVS. However, the radiology RVS offers several improvements over the RBRVS. First the radiology RVS relied on both data and physician expertise to determine the relative relationships, while the RBRVS relied almost exclusively on data. Furthermore, nearly 1200 radiologists participated in the radiology RVS, compared to 100 in the RBRVS.

- Time data (and other data collected by the ACR RVS survey) are used to substantiate the current RVWs for radiology.

Contained in the document are charts depicting procedural time estimates from the ACR RVS survey. This data, plus time estimates from Hsiao and the AMA's RVS Update Committee, are used to demonstrate that the existing relative values reflect the current practice of radiology and are in proper relationship to other medical services.

- The current physician work relative values (RVWs) for plain film studies accurately reflect the work involved in the procedure and, therefore, should be maintained.

Contrary to the carrier medical directors' (CMDs) comments, plain film studies require physician involvement. Moreover, there is more work associated with interpreting a study than reviewing one. With respect to other radiologic modalities (e.g. MRI, CT, ultrasound), plain film studies exhibit the proper relationship. These points are well supported by time data from the ACR, an intensity (RVW/time) analysis, and comparisons to evaluation and management services. The CMDs, on the other hand, offer no objective foundation for their recommendations.

- The current RVWs for contrast studies should be retained since they reflect the work involved.

The CMDs recommendations for contrast studies fail to take into account the nature of the procedure and the physician work required. Radiologists are integrally involved in performing contrast studies. A radiologist must ensure

the quality of the study and interpret both the resulting fluoroscopic and plain film images. In addition, the radiologist may interpret other pertinent studies as part of the study. Contrast material adds to the clinical information to be interpreted; thus making the procedure harder, not easier to interpret (as the CMDs believe).

- Objective data and analyses support the current RVWs for MRI.

The existing RVWs for MRI are well supported by time data, an intensity analysis, and comparison to evaluation and management services. The same cannot be said about the CMD-proposed values since no objective data supporting their recommendations were presented. Furthermore, the number of images per study speaks against the CMDs' contention that the RVW for MRI should be the same regardless of anatomic site imaged.

- Unlike the CMDs' RVW recommendations, the existing RVWs for CT are well supported by data and analysis.

Time data and an intensity analysis confirm the fact that the current values reflect the work involved in CT. Furthermore, the number of images per CT study rebuts the CMDs' notion that the RVWs for CT should be the same regardless of site imaged. Consequently, the current RVWs for CT should be maintained.

- The presence of contrast material adds to the physician work for MRI and CT studies.

Contrast material allows more anatomy to be visualized. In addition, there is the work of injecting the contrast (usually done by the radiologist) which is included in the basic study. Finally, there is the risk associated with contrast reactions.

- The current RVWs for radiology were based on extensive survey data and statistical analyses. Current data and analyses substantiate these values. The CMDs' proposed values, which are not based on objective sources, should be discarded in favor of the current values.

Introduction:

The purpose of this report is to respond to the comments from the carrier medical directors regarding radiology. In doing so, we will present both qualitative and quantitative arguments based on data collected by the RUC, Hsiao, and the ACR.

The report is divided into seven major sections:

- I. Development of the Radiology Relative Value Scale (RVS)
- II. Physician Work Relative Values (RVWs) for Plain Film Studies
- III. Physician Work Relative Values (RVWs) for Simple Planar Contrast Studies
- IV. Physician Work Relative Values (RVWs) for MRI Studies
- V. Physician Work Relative Values (RVWs) for CT Studies
- VI. Physician Work Relative Values (RVWs) for MRI and CT with Contrast
- VII. Conclusion
- VIII. Technical Discussion
- IX. Attachments and Appendix

I. Development of the Radiology Relative Value Scale (RVS)

The Omnibus Budget Reconciliation Act of 1987 (OBRA87) provided for relative value scales for radiology, as well as anesthesiology and pathology. Accordingly, the ACR set out to develop an RVS for radiology.

To estimate physician work, the ACR defined "complexity" as overall time plus Hsiao's components of physician effort or intensity (technical skill and physical effort, mental effort and judgment, quality control and assurance, and iatrogenic risk). Complexity was measured using magnitude estimation. The benchmark procedure used for the radiology RVS was the intravenous pyelogram or IVP (CPT code 74400). The IVP was chosen because it is commonly done and well understood by radiologists. The magnitude estimation survey covered 45 procedures (with vignettes) and went out to over 2,000 radiologists, of which 1,173 responded.

In addition to magnitude estimation, a charge survey was mailed to all of the nearly 3,000 radiology groups in the United States; responses were received from nearly 1,800. The practices provided 1987 professional and global charges for each procedure and the frequency with which each procedure was performed.

A consensus panel process assigned relative values to procedures. A steering committee, in which rested final authority regarding relative values, was in charge of the process. Reporting to the steering committee were seven specialized panels. The panels represented each of the major radiologic subspecialties: general radiology, interventional radiology, computerized tomography (CT) and magnetic resonance (MR), nuclear medicine, radiation oncology, and ultrasound. (The seventh panel dealt with technical component costs.) Composition of the panels ranged from four to eleven members; each was chaired by a steering committee member, and all steering committee members served on a panel. To provide broad experience and perspective, the members of both the steering committee and specialty panels came from academic and nonacademic practices, all geographic regions in the United States, many radiologic subspecialty organizations, and all subspecialties. In total, nearly forty radiologists and radiation oncologists participated in the process, each spending approximately 200 hours.

For the professional RVS (which includes the physician work relative value), the nearly 800 radiologic procedures were divided among the six subspecialty panels according to the subspecialty that performed the procedure most frequently. Each panel received magnitude estimate-derived relative values and charge-based relative values for procedures

within its purview. (For examples of the worksheets used by the panels, see Attachment 1.) Each of the relative values had the IVP as its base. (The IVP also happens to be one of the CMDs' reference procedures for radiology.) Although the magnitude estimation survey was limited to 45 procedures, they represented the broad spectrum of radiologic practice. Related procedures were grouped around these 45 "primary" procedures in families or "trees." This process was expanded until every radiology procedure was classified as either "primary," "secondary," or "tertiary."

The subspecialty panels began their work by first setting the relationships between the primary procedures. Their instructions were to compare the various sources of relative value information (e.g. charge, magnitude estimation) and apply their professional expertise and experience. "Outlier" procedures were identified through a comparison of the charge-based RVS to magnitude estimates. To help ensure objectivity, the subspecialty panels had to justify their recommendations in writing. Once each subspecialty panel completed its work on its primary procedures, it turned to the secondary and tertiary procedures in a similar manner. A computer spreadsheet program automatically re-calibrated the intra-family RVS on the basis of any change.

The work of the subspecialty panels was aggregated and presented to the steering committee, with each panel chair defending its values. With the intra-specialty values established by the subspecialty panels, the steering committee concentrated its efforts on the interspecialty relationships. The steering committee adhered to the same process and documentation requirements that the subspecialty panels followed.

The professional component relative values, when finalized, contained substantial changes. Relative to charge-based relative values, average (unweighted) changes by subspecialty were as follows: general radiology, -2%; interventional radiology, +7%; CT and MR, -12%; ultrasound, -2%; nuclear medicine, -16%; and radiation oncology, +6%.

In the context of the carrier medical directors' evaluation of radiology procedures, there are some important points that need to be emphasized regarding the radiology RVS:

- **The ACR's RVS was accepted by the Health Care Financing Administration (HCFA) without changes to the relative values.**
- **The radiology RVS was calculated to be budget neutral less three percent (per HCFA). Therefore, there was no incentive to "game" the procedures.**

- The Physician Payment Review Commission (PPRC) estimated that radiology was “overvalued” relative to the rest of medicine by 21 percent. However, because of the way the radiology RVS was incorporated into the RBRVS by Hsiao (through the use of “equivalent” links rather than “identical” links), total reductions scheduled to occur through 1996 are 35 percent – 14 percent more than the PPRC’s original estimate.
- The radiology RVS offers several improvements over the RBRVS . The radiology RVS relied on both data and physician expertise to determine the relative relationships. The RBRVS relied almost exclusively on data. The radiology RVS was derived using more data. Nearly 1,200 radiologists participated in the ACR’s magnitude estimation surveys, compared to 100 physicians (not all of whom were diagnostic radiologists) under the RBRVS.

II. Physician Work Relative Values (RVWs) for Plain Film Studies

Description of Procedure

Plain film radiography requires physician involvement. Prior to the study, the radiologist reviews the patient’s history. In addition, the radiologist is responsible for ensuring that the appropriate views are obtained and that the films are of diagnostic quality. Once satisfied that the films are to specifications, the radiologist then will interpret them. Also, when appropriate, the radiologist will review other pertinent exams in order to correlate the findings with the current exam and with the clinical findings. This information will be conveyed to the referring physician in a written report and verbally, if appropriate.

Relativity

Plain film studies currently exhibit the proper relationship with respect to other radiology procedures (e.g. MR, CT, ultrasound, and interventional radiology). When developing the relative values for plain film studies, the IVP (code 74400) was the benchmark, and six of the eight CMD reference codes (70551, 74020, 74280, 74400, 76700, 76805) served as primary or anchoring codes. It was the responsibility of the steering committee to ensure that the modalities were in proper relationship to one another. (See Section I.) Since the steering committee was comprised of radiologists, and radiologists perform the vast majority of radiology procedures, there was no other group better suited to accomplish such a task.

Within plain film studies, there are differences in physician work. Such variables as the number of views and the complexity of the anatomy

impact upon the RVW. Currently, the RVWs for plain film radiography range from 0.10 (single view teeth) to 0.45 (two views of the entire spine). Flat reductions, such as those proposed, would disrupt these relationships.

Other sections in medicine are affected by the CMDs' recommendations for plain film radiography. Many codes in the pathology section (80000 series of CPT) and the medicine section (90000 series of CPT) were judged to require less physician work than a two view chest x-ray (code 71020). (For example, see the CMDs' recommendations for codes 94240, 94350, 94720, and 94725.) However, in comparison to these procedures, the chest x-ray has the same or lower RVW.

Time and Intensity

Table 1 presents the time estimates for plain film radiography. The two sources of time data are from ACR and Hsiao. Both sources relied on surveys to collect time estimates. In the ACR survey, between 443 to 910 radiologists provided time estimates for the codes listed. Radiologists participated in the Hsiao studies, although far fewer than those in the ACR survey. The CMDs, on the other hand, offer no time data to support their conclusions.

Table 1: Time Estimates for Plain Film Radiography

CPT Code	Description	Mean Time in Minutes	Median Time in Minutes	Source(s) of Time Data
70150	X-ray exam, facial bones	5	5	Hsiao IV
70220	X-ray exam, sinuses	5	5	ACR
70260	X-ray exam, skull	8.05	8.6	ACR, Hsiao I
71010	X-ray exam, chest one view	5	5	Hsiao IV
71020	X-ray exam, chest two views	6.18	5.7	ACR, Hsiao I & IV
71111	X-ray exam, ribs and chest	9.5	9.5	Hsiao I
72020	X-ray exam, spine	3	3	Hsiao IV
72110	X-ray exam, lumbar spine	8.56	9.8	ACR, Hsiao I
73110	X-ray exam, wrist	6.88	5	ACR
73140	X-ray exam, finger(s)	6.70	3	ACR
73510	X-ray exam, hip	8	8	Hsiao I
73562	X-ray exam, knee	7.39	5	ACR
73610	X-ray exam, ankle	5.7	5.7	Hsiao I
73620	X-ray exam, foot	3	3	Hsiao I
74020	X-ray exam, abdomen	7.28	7.15	ACR, Hsiao I & IV

Using the time data for radiology procedures from Table 1 and the 1995 RVWs, RVW/time ratios (i.e. intensity) were calculated for 15 plain film studies from the CMDs' list. (For more information, refer to the Technical Discussion.) This analysis revealed no outliers. Therefore, plain film procedures have RVWs that are consistent with respect to procedure intensity.

Time Comparison to E/M Services

Comparison to E/M services on basis of time offers a further validation of the current values for plain film studies. One E/M service that offers a meaningful comparison to plain film studies is code 99211 (a level one office visit). This procedure is noteworthy in this discussion because its RVW (0.17) is comparable to that of plain film studies (range 0.10 to 0.45, most between 0.16 to 0.28). Furthermore, code 99211 is for the evaluation and management of an established patient that may not require the presence of a physician. The presenting problems are minimal and five minutes are spent performing the service. Examples are:

- Office visit with 12 year old male, established patient, for cursory check of hematoma one day after venipuncture.
- Office visit with 31 year old female, established patient, for return to work certificate.
- Office visit for a 42 year old established patient to read tuberculin test.
- Office visit for a 14 year old female, established patient, to re-dress an abrasion.
- Office visit for a 45 year old female, established patient, for a blood pressure check.
- Office visit for a 23 year old established patient for instruction in use of a peak flow meter.

Plain film studies, on the other hand, require the involvement of a physician. Only a physician can interpret a study and from that render a report. Therefore, a serious flaw would be created in the RBRVS if physician services are valued at or below services not requiring physician work.

Another comparison to E/M services that serves to support the current values for plain film studies involves code 99213 (a level 3 visit). As purported by the CMDs, code 99213 involves 15 minutes of physician time. A radiologist spends a total of 6 minutes for a two view chest x-ray (code 71020). Comparing the two times results in a ratio of 0.40 (6/15). It

follows then -- if code 71020 is properly valued, its RVW should be 40 percent of that for code 99213. Multiplying the RVW (0.55) for code 99213 by 0.40 results in an RVW of 0.22 which happens to be the current RVW for code 71020. This same approach was applied to the other plain film studies identified by the CMDs, and the results support the current RVWs. (See the Technical Discussion for the analysis.)

In conclusion, the comparison of plain film studies to E/M services on the basis of time alone supports the current RVWs rather than the CMDs' recommendations. The CMDs' proposed values fare much worse with respect to E/M services.

Need for Supervision

As mentioned in the discussion on the development of the radiology RVS, quality control and assurance was one of the components of physician effort or intensity measured by the ACR. The need for supervision would fall within this component of physician work.

The ACR defined quality control and assurance as:

- The time and expense needed to acquire and maintain technical skills for the physician and staff.
- The effort needed to make the procedure technically excellent and keep the radiation dosage as low as reasonably possible.
- The effort needed to monitor and train staff and to document monitoring activities.
- Any other activities that assure the quality of the professional services or consultation.

Since quality control and assurance effort is a component of physician work, it follows then that the two should be positively related. In other words, procedures requiring less quality control and assurance effort should have lower RVWs than procedures requiring more effort. One would expect to find plain film radiography at the lower end of the quality control spectrum and procedures such as MRI or interventional radiology towards the other end. This hypothesis was tested by comparing the current RVWs to the quality assurance score from the radiology RVS. This analysis showed a positive relationship between quality assurance and RVW. In addition, the quality assurance-RVW relationship was uniform within the modalities. (For more information, see the Technical Discussion.) Consequently, the current relative values with respect to quality control and assurance effort are appropriate.

Broader Cognitive Skills

A general radiology residency is of five years duration (many residents take an extra fellowship year or two in a subspecialty). During those five years, a radiologist must acquire cognitive knowledge (85% of the time is spent in interpreting images versus performing procedures) that crosses virtually the entire spectrum of medicine.

Reviewing vs. Interpreting Radiologic Examinations

The physician work expended by a radiologist when interpreting a radiographic study is different and considerably greater than simply reviewing a set of films. It is inappropriate to equate the two.

There are many facets in a radiological interpretation or consultation. (See Attachment 2 for more details.) Prior to interpreting the films, the radiologist must evaluate the quality of the films. The radiologist is responsible for ensuring that the films convey the needed information on which to render a diagnosis. In addition, the radiologist is required to report all findings from the films, not just those in the area of interest. In order to reach a conclusion, previous films and/or reports may be consulted, when appropriate. Finally, the results are communicated to the referring physician, if appropriate, and placed in a written report.

In addition, the "review" of studies does not expose the "reviewing" physician to the malpractice risk assumed by the radiologist who interprets the exam and puts his/her name on the report. Among the most common causes for malpractice claims against radiologists are alleged misdiagnoses of breast cancer on mammograms, lung cancer on chest films, and missed fractures on bone films.

Given the attention to detail a radiologist commits to plain film studies, it would be incorrect to believe that several studies could be "reviewed" during most visits to address a problem of "low to moderate severity."

III. Physician Work Relative Values (RVWs) for Simple Planar Contrast Studies

Description of Procedure

The inability of plain film studies to image soft tissues (e.g. cartilage) can be overcome by introducing a contrast material. Contrast agents block the passage of x-rays through the area of interest. For contrast procedures (e.g. arthrograms, myelograms), the contrast material must be injected into the desired location.

Radiologists are integrally involved in performing contrast studies. Prior to performing a myelogram for example, the radiologist reviews the patient's history (particularly for contraindications) and ensures that the patient is ready to undergo the study (e.g. proper hydration, vital signs and neurologic level within acceptable limits). Once the radiologist is satisfied that the patient is properly prepared, contrast is injected by the radiologist or another physician (separately reported). Afterwards, under fluoroscopic monitoring, the radiologist positions the patient and obtains appropriate fluoroscopic spot films. The resulting films and fluoroscope images are interpreted by the radiologist. In addition to images from the study, other pertinent studies may be reviewed in order to reach a diagnosis. Post-procedure care involves adequate hydration and observation for possible signs of contrast reactions. If a contrast reaction occurs, the radiologist must be ready to manage the complication. The results of the study are prepared in a final report and communicated to the referring physician, if appropriate. Although the physician work described above is for a myelogram, the other contrast studies (e.g., arthrograms) share the many of the same characteristics.

Relativity

The argument for lowering the RVWs for contrast studies (e.g. arthrograms, myelograms) to the level of plain film studies fails to take into account how and why these procedures are performed.

Contrast material adds to the clinical information to be interpreted, thus making contrast procedures harder, not easier, to interpret. Contrast material is injected to visualize anatomy not evident on plain films (e.g., joint cartilage, spinal cord and its membranes, bronchial tree, and ductal system). Consequently, the structures visualized by the injected contrast material must be evaluated.

Preliminary films can be obtained prior to the injection of contrast material and, if so, are included in the work of interpreting a contrast study. Alternatively, previous studies could be used, if available. In either case, the plain film studies must be reviewed. In total, there are two to three times more films to interpret in these examinations than for plain film studies. For example, a shoulder exam may consist of only two views, while an arthrogram of the same site requires at least six views. As another example, at least eight views comprise a lumbar myelogram, while a lumbosacral spine x-ray may have only two.

Finally, the fact that fluoroscopy is an integral part of the work of these procedures (only exception is dacrocystography) was overlooked. Fluoroscopy is not separately billed in addition to the primary code.

One of the accepted ways of developing a relative value for a comprehensive service is through a building-block approach in which the relative values for component codes are added together to form the new value. Following this approach, the current RVWs for contrast studies are well justified. For example, it was reported earlier that a shoulder arthrogram requires fluoroscopy and six views. The RVW for a shoulder arthrogram then would equal –

Code 73030 (Two view shoulder), RVW = 0.18

Code 76000 (Fluoroscopy), RVW = 0.17

Code 73040 (Shoulder arthrogram), $RVW = 3*(0.18) + (0.17) = 0.71$

[A shoulder arthrogram currently has an RVW of 0.54.]

Similarly, for a lumbar myelogram –

Code 72100 (Two view lumbosacral spine), RVW = 0.22

Code 76000 (Fluoroscopy), RVW = 0.17

Code 72265 (Lumbar myelogram), $RVW = 4*(0.22) + (0.17) = 1.05$

[A lumbar myelogram currently has an RVW of 0.83.]

Although the sum of the component procedure results in an RVW that is higher than the current value, these procedures are not considered to be undervalued. These examples fail to take into account the economy of scale associated with interpreting multiple films during the same session.

V. Physician Work Relative Values (RVWs) for MRI Studies

Description of Procedure

Magnetic resonance imaging (MRI) creates images by placing the body in a magnetic field and using radio waves to obtain responses from the body. The magnetic field aligns the atoms in the patient's body in a polar formation. When a radio signal is introduced, the protons spinning in the hydrogen atoms in the body are momentarily knocked off course. When the signal is turned off and the protons return to their orbit, the atoms emit a faint radio signal. These signals are translated into dots on the computer screen. These dots, in turn, form images to be interpreted.

The radiologist is involved in all aspects of an MRI study. Before the procedure is performed, the radiologist discusses the examination with the patient and instructs the technologist as to the appropriate pulse sequences. The patient then is placed into the scanner and imaged. The radiologist ensures that the examination provides images with suitable contrast characteristics, spatial resolution, signal-to-noise ratio, and section geometry relevant to the specific clinical indication. Afterwards,

the radiologist interprets the images and determines if additional pulse sequences or studies are needed. The results are conveyed to the referring physician through a written report dictated by the radiologist. The radiologist may also contact the referring physician with the results, if appropriate.

Time

Table 2 presents the time estimates for MRI. The two sources of time data are from ACR and the RUC. Both sources used extensive surveys to estimate time. For the three MRI procedures in the ACR survey (70551, 71550, 72148), between 379 and 749 radiologists provided time estimates. Physicians from multiple specialties (radiology, interventional radiology, cardiology and neurology) participated in the RUC survey, with at least sixty radiologists providing time estimates. Conversely, the CMDs offer no time data to support their recommendations.

Table 2: Time Estimates for MRI

CPT Code	Description	Mean Time in Minutes	Median Time in Minutes	Source(s) of Time Data
70541	MR angiography, head	Not Reported	40	RUC
70551	MRI, brain	49.41	20	ACR
71550	MRI, chest	54.55	30	ACR
71555	MR angiography, head	Not Reported	40	RUC
72148	MRI, l-spine, w/o contrst	50.35	20	ACR
72159	MR angiography, spine	Not Reported	45	RUC
72198	MR angiography, pelvis	Not Reported	35	RUC
73225	MR angiography, up. ext.	Not Reported	40	RUC
73725	MR angiography, lw. ext.	Not Reported	40	RUC
74185	MR angiography, abdomen	Not Reported	40	RUC
75552	MRI, myocardium	Not Reported	90	RUC
75554	MRI, myocardium	Not Reported	150	RUC
75555	MRI, cardiac function	Not Reported	100	RUC

Relativity

Physician work for MRI is related (but not entirely) to the number of images to interpret. Any argument that assigns the same the RVWs regardless of site ignores the fact that large sites require more slices (resulting in more images) than do small sites. In addition, some sites (such as joints) require more elaborate imaging sequences (e.g. narrower slices, multiple projections, reconstruction) in order to properly image the area than do other sites. Consequently, in either case, this leads to more

images to interpret, thus more physician time. (See Attachment 3 for the number of images associated with MR.)

As for plain film studies, a comparison to E/M services supports the current values for MRI. It is estimated that the total physician time for code 72148 (MRI, lumbar spine, without contrast) is 35 minutes. Based on times estimates alone, code 72148 should have an RVW between that for code 99235 (30 minutes; RVW = 1.47) and 99215 (40 minutes; RVW = 1.51). With an RVW of 1.48, code 72148 is properly valued with respect to the two E & M codes cited. Again, this comparison (like that for code 71020) underscores the point that MRI services are properly valued.

V. Physician Work Relative Values (RVW) for CT Studies

Description of Procedure

Computerized axial tomography (CAT or CT) employs x-rays to image the body in cross-sectional "slices." A computer is used to reconstruct the images into a three-dimensional image.

The radiologist is an integral part of a CT study. Before the procedure is performed, the radiologist discusses the examination with the patient and instructs the technologist regarding the area to be imaged and the width of the "slices." The patient is then placed into the scanner and imaged. The radiologist ensures that the examination provides images that are suitable and relevant to the specific clinical indication. Afterwards, the radiologist interprets the images and determines if additional slices or other studies are needed. The results are conveyed to the referring physician through a written report dictated by the radiologist. The radiologist may also contact the referring physician with the results, if appropriate.

Time

Table 3 presents the time estimates for CT. The two sources of time data are from ACR and Hsiao. Both sources relied on surveys to collect time estimates. In the ACR survey, between 424 to 885 radiologists provided time estimates for the codes listed. Radiologists participated in the Hsiao studies, although far fewer than those in the ACR survey. (Hsiao's time estimate for code 70450 is suspected to be in error; 10 minutes is more appropriate.) The CMDs, on the other hand, offer no time data to support their conclusions.

Table 3: Time Estimates for CT

CPT Code	Description	Mean Time in Minutes	Median Time in Minutes	Source(s) of Time Data
70450	CT, brain, w/o contrast	6	6	Hsiao IV
70470	CT, brain, w/o & w/contrast	33.06	20	ACR
71250	CT, chest, w/o contrast	34.50	20	ACR
72131	CT, l-spine w/o contrast	34.60	20	ACR
74160	CT, abdomen, w/o contrast	24.5	22.4	ACR, Hsiao I & IV

Relativity

Similar to MRI, physician work for CT is related to the number of images to interpret. Therefore, assigning the same RVW to CT procedures without considering the work involved would create a flaw in the RBRVS. As in MRI, the number of images depends on the body site and the complexity of the anatomy under consideration. That is, large or complicated sites require more work than small or less demanding areas. (See Attachment 4 for the number of images associated with CT.)

VI. Physician Work Relative Values (RVWs) for MRI and CT Studies With Contrast

Description of Procedure

For CT and MRI, as for contrast studies, the presence of contrast material visualizes additional anatomy, both normal and abnormal, for the radiologist to evaluate, thus increasing the work. In addition, the pattern and intensity of the vascular enhancement of structures, both normal and abnormal, by the injected contrast material must be evaluated and the appropriate significance attached.

Also, there is work and risk associated with the injection of contrast material. In most facilities, contrast material is injected by the radiologist and not separately reported.

Contrast media reactions are not rare. Most side effects are mild to moderate and occur in 5-12% of patients. Serious reactions occur in one or two per 1,000 examinations (ACR Manual on Iodinated Contrast Media, 1991).

Deaths are reported in one per 40,000 (Ansel G. Adverse reaction to contrast agents: scope of the problem. *Invest. Radiology* 1970; 5: 374-379) to one per 170,000 examinations (Katayama H., et al. Adverse reactions to ionic and non-ionic contrast media. *Radiology* 1990; 175: 621-628).

Selective usage of low osmolar contrast material has lowered the incidence of minor to moderate reactions. However, there is no evidence that its use has decreased severe reactions significantly, nor has it decreased the number of deaths. Besides the risk of systemic reactions to contrast material, there is the additional risk of extravasation leading to significant local tissue damage.

It is the responsibility of the radiologist to appropriately treat contrast reactions. The radiologist usually treats minor or moderate reactions without assistance. The radiologist may or may not be assisted by other physicians in the treatment of severe reactions. In any case, the radiologist does not submit additional codes for the work involved in treating these contrast reactions.

Relativity

Comparable reference codes for the injection part of the study have RVWs ranging from 0.18 (code 36000) to 0.95 (code 36005).

VII. Conclusion

The current relative values for radiology were based on extensive survey data and statistical analyses. Moreover, there is no evidence to suggest that the physician work values have changed since originally valued. This data and others from the RUC and Hsiao have confirmed that, for the procedures identified by the CMDs, the current physician work relative values are appropriate.

VIII. Technical Discussion

Intensity Analysis

Physician work is defined as the product of the time it takes a physician to perform a procedure and the intensity of the physician's effort. [In other words, $Work = Time \times Intensity$.] Intensity, therefore, can be expressed as the ratio of work per unit of time. [Mathematically, $Intensity = Work/Time$.]

This concept can be used to test for the presence of misvalued procedures. A procedure that has a high intensity estimate but low RVW could be

undervalued. Conversely, a low intensity score and a high RVW could be indicative of an overvalued procedure. However, it would be difficult, if not meaningless, to look at individual intensity estimates without a frame of reference. The aggregate intensity for a specialty or family of codes provides such a basis for comparison.

Using the three main sources of time data for radiology procedures (RUC, Hsiao, and ACR), RVW/time ratios (i.e. intensity) were calculated for nearly eighty radiology procedures. (See Attachment 5.) In addition, the same analysis was conducted for the plain film studies, CT, and MRI procedures identified by the CMDs. (See Attachment 6, 7, 8 respectively.) All but one of the radiology codes analyzed had ratios within two standard deviations around the mean (or in other words, a 95% confidence interval). The sole outlier, code 70450, is one because of an erroneous time estimate from Hsiao. If Hsiao's time estimate for code 70450 is replaced with one more appropriate (10 minutes), then this procedure would no longer be an outlier. (It is ironic that this procedure has a proposed RVW-increase.) Therefore, this analysis shows that radiology procedures, even those identified by the CMDs, have RVWs that are consistent with respect to intensity.

Time

Many of the arguments presented in this report for retaining the current RVWs are based on time data collected in 1988. It is important, therefore, to ascertain whether or not the 1988 data are relevant today. First of all, there is no evidence of changes in procedure time for radiology in the peer-review literature. Besides ACR time, the report's analyses include time data from Hsiao and the RUC.

Another source of current time data for radiology is from the survey conducted as part of the Five-Year Review of the RBRVS. The survey questionnaire requests for time estimates for each reference code used to estimate the RVW for the code being rated. The time estimates for the reference codes, once aggregated, can be used to test the 1988 time estimates.

Since the survey questionnaire does not restrict the respondent to specific reference codes, the resulting database consists of a wide range of services – many of which have only a few respondents. Therefore, in order to control for variability, only codes which had a minimum of ten respondents were used in the analysis. In addition, the analysis utilizes median time estimates. As the following below table shows, three procedures were surveyed both in 1988 and 1995 and passed the aforementioned stipulations.

The procedures in the analysis provide valuable insight into the stability of the ACR's time data. First of all, the three procedures in the analysis are from the CMDs' list. Also, two of the three radiologic modalities identified by the CMDs (MRI and plain film) are included in the analysis. Finally, two of the three procedures in the analysis (70551 and 71020) were used by the CMDs as references in developing their proposed values (70551 for radiology, 71020 for non-radiologic services).

Comparison 1988 ACR Time Estimates to 1995 ACR Time Estimates

CPT Code	Description	1988 ACR Median Time	1995 ACR Median Time (# obs)	Ratio: 1995 ACR Time to 1988 ACR Time
70551	MRI, brain, w/o contrast	20	24 n=14	1.20
71020	X-ray exam, chest two views	5	5 n=52	1.00
72148	MRI, l-spine, w/o contrast	20	20 n=124	1.00

In summary, the ACR's 1988 time data appear to reflect the current practice of radiology. Furthermore, the analyses in this report incorporate more recent time data (e.g. RUC, Hsiao). Therefore, this report's conclusions are unaffected by the use of previous survey data.

Quality Assurance Versus RVW Analysis

Since quality control and assurance effort are components of physician work, it follows then that the two should be positively related. To test this hypothesis, the median quality control and assurance score from the ACR magnitude estimation survey was plotted against RVW for the fifteen codes identified by the CMDs to be misvalued. (See Attachment 9.) As predicted, there is a positive linear relationship between quality control and assurance and the current RVWs. In fact, there is a rather tight fit between the two variables (a Pearson's correlation coefficient of 0.95, where 1.0 is perfect). Furthermore, the points for the various radiologic modalities (plain film, CT, MR) clustered within the same area. The clustering of the data points illustrates the internal consistency of the radiology RVS with respect to the radiology modalities.

Comparison to E/M Services

Intra-specialty comparisons serve to address questions of internal consistency. However, comparisons outside of one's specialty

demonstrate the relationship with respect to all of medicine. Linkages to E/M codes have the major advantage of being the "common denominator" for medicine since the majority of physicians use the codes.

Earlier in this report, the RVW for a two view chest x-ray (code 71020) was compared to two E/M services (codes 99211 and 99213) on the basis of time. This analysis upheld the current RVW for code 71020. Taking this approach one step further, the RVWs for the other plain film studies identified by the CMDs are estimated using code 99213 as the benchmark. As the following table demonstrates, the current RVWs are a much better match to the code 99213-based RVWs than the proposed new values.

Code	1995 RVW	Estimated RVW (with code 99213 as base)	CMD Proposed RVW	Difference 1995 RVW vs. Estimated RVW	Difference CMD RVW vs. Estimated RVW
70150	0.26	<u>0.18</u>	0.20	+6	+2
70220	0.25	<u>0.18</u>	0.19	+7	+1
70260	0.34	<u>0.30</u>	0.28	+4	-2
71010	0.18	0.18	0.12	0	-6
71111	0.32	<i>0.35</i>	0.26	-3	-9
72020	0.15	<u>0.11</u>	0.10	+4	-1
72110	0.31	0.31	0.25	0	-6
73110	0.17	<i>0.22</i>	0.11	-5	-11
73140	0.13	<i>0.18</i>	0.19	-5	+1
73510	0.21	<i>0.29</i>	0.15	-8	-14
73562	0.18	<i>0.23</i>	0.12	-5	-11
73610	0.17	<i>0.21</i>	0.11	-4	-10
73620	0.16	<u>0.11</u>	0.10	+5	-1
74020	0.27	0.27	0.21	0	-6
				Average -0.29	Average -5.2

For the fourteen plain film codes analyzed in the manner described earlier, there were three exact matches (in bold) between the current RVWs and the estimated values. In addition, six procedures (in italics) would have their RVWs increased and five (underlined) would have their RVWs reduced. Conversely, there were no exact matches between the estimated and CMD-proposed values. Furthermore, most of the CMD-proposed values were below the estimated ones.

Sampling Analysis

It is common statistical convention to base a sample on a 95 percent confidence interval. The ACR's 1988 RVS survey achieved this standard. Consequently, a repeat of that survey would produce similar results because the population has not change appreciably, nor have the basic procedures being sampled changed. In addition, any re-survey, in order for it to have the same validity as the 1988 survey, would require a sample size comparable to that used in 1988.

By studying a limited number of cases (i.e. a sample), one can make inferences from the survey results about the total population. In order for these inferences to be accurate, the sample must be of the appropriate size. Sample size is influenced by two basic factors: (1) the population to which inferences will be made, and (2) the desired precision (i.e. confidence interval, variance). Simply put, the larger the population and the greater the desired accuracy, the larger the sample size. However, a population increase does not require a proportionate sample size increase. For example, a population of 1,000 would require a sample size of 696; a population of 20,000, a sample of 1013; a population 500,000 or more, a sample of 1065. (Source: Nan Lin *Foundations of Social Research*,.)

In 1988, the number of board certified radiologists in the U.S. (including nuclear medicine physicians) totaled approximately 19,000. Today, the number of board certified radiologists is approximately 23,000. (Source: *AMA Physician Characteristics and Distribution in the U.S.*) Therefore, in 1988 the sample size required to achieve a 95 percent confidence interval was 1,010, and would change only to 1,020 today. The ACR's 1988 RVS survey went out to 2,000 radiologists and nuclear medicine physicians, of which 1,173 responded. Therefore, duplicating the 1988 survey would not produce different results because the sampling requirements needed for accurate results in both 1988 and 1995 are basically the same.

IX. Attachments and Appendix

Attachment 1

Investigator ID: _____

AMERICAN COLLEGE OF RADIOLOGY
RELATIVE VALUE STUDY

Worksheet

PROCEDURE		RELATIVE VALUE based on:			
CPT-4 Code	Description	Charge Survey (pilot)	Complexity and Time: Wght.Avg.*	(2)/(1)	
THE STANDARD: 74400		(1)	(2)	(3)	(4)
Intravenous urography, pyelography, with or without KUB		100	100	1.00	100
73630	Complete foot exam; min 3 views	34	32	.93	
71020	Two view chest exam frontal and lateral	40	42	1.06	
73510	Complete hip exam; min. 2 views	43	41	.94	
70220	Sinuses exam complete, paranasal, min 3 views	54	39	.72	
74020	Complete abdomen exam including decubitus and/or erect views	56	43	.76	
72110	Complete spine exam, lumbosacral with oblique views	63	46	.73	
76091	Bilateral mammography	77	92	1.18	
78006	Thyroid imaging, with uptake; single determination	119	77	.64	
76805	Echography, pregnant uterus, b-scan and/or real time with image documentation; complete	122	183	1.51	
74280	Colon exam; air contrast with specific high density barium, with or without glucagon	132	258	1.95	
78585	Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath	159	116	.73	
78215	Liver and spleen imaging; static only	173	83	.48	
78305	Bone imaging; multiple areas	173	84	.49	
78471	Cardiac blood pool imaging, gated equilibrium, at rest, wall motion study plus ejection fraction	200	148	.74	

* The values for this scale represent a weighted average of pilot survey responses for complexity and time, using weights as follows: complexity - .75; and time - .25.

AMERICAN COLLEGE OF RADIOLOGY
RELATIVE VALUE STUDY

Worksheet
(continued)

PROCEDURE		RELATIVE VALUE based on:			
CPT-4 Code	Description	Charge Survey (pilot)	Complexity and Time: Wght.Avg.*	(2)/(1)	
THE STANDARD: 74400	Intravenous urography, pyelography, with or without KUB	(1) 100	(2) 100	(3) 1.00	(4) 100
93870	Non-invasive studies of carotid artery, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution b-scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis)	205	183	.90	
73581	Knee arthrography exam; complete	244	241	.99	
70470	Head CT; without contrast material followed by contrast material(s) and further sections	251	179	.71	
131	Computerized axial tomography, lumbar spine; without contrast material	283	171	.60	
74160	Abdomen CT; with contrast	287	213	.74	
70551	MR (e.g., proton) imaging, brain (including brain stem)	378	201	.53	
74321	Complete cholangiography, percutaneous, transhepatic	396	425	1.07	
71037	Needle biopsy of intrathoracic lesion, including follow-up films; complete procedure	631	438	.69	
75990	Drainage of abscess, percutaneous, with radiologic guidance (i.e., fluoroscopy, ultrasound, or computed tomography); with or without placement of indwelling catheter	701	525	.75	
75657	Cervicocerebral angiography, including vessel origin; selective catheter; 3 or 4 vessels, complete	946	850	.90	
75963	Percutaneous transluminal angioplasty, peripheral artery; complete procedure	1,622	675	.42	

*The values for this scale represent a weighted average of pilot survey responses for complexity and time, using weights as follows: complexity - .75; and time - .25.

AMERICAN COLLEGE OF RADIOLOGY
RELATIVE VALUE STUDY

Worksheet

PROCEDURE		RELATIVE VALUE based on:			
CPT-4 Code	Description	Charge Survey (pilot)	Critical Factors: Wght.Avg.*	(2)/(1)	
THE STANDARD: 74400	Intravenous urography, pyelography, with or without KUB	(1) 100	(2) 100	(3) 1.00	(4) 100
73630	Complete foot exam; min 3 views	34	36	1.05	
71020	Two view chest exam frontal and lateral	40	36	.91	
73510	Complete hip exam; min. 2 views	43	45	1.04	
70220	Sinuses exam complete, paranasal, min 3 views	54	36	.67	
74020	Complete abdomen exam including decubitus and/or erect views	56	50	.90	
72110	Complete spine exam, lumbosacral with oblique views	63	50	.79	
76091	Bilateral mammography	77	89	1.15	
78006	Thyroid imaging, with uptake; single determination	119	73	.62	
76805	Echography, pregnant uterus, b-scan and/or real time with image documentation; complete	122	206	1.70	
74280	Colon exam; air contrast with specific high density barium, with or without glucagon	132	280	2.11	
78585	Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath	159	115	.73	
78215	Liver and spleen imaging; static only	173	86	.50	
78305	Bone imaging; multiple areas	173	93	.53	
78471	Cardiac blood pool imaging, gated equilibrium, at rest, wall motion study plus ejection fraction	200	142	.71	

* The values for this scale represent a weighted average of pilot survey responses for 4 critical factors, using weights as follows:

technical skill and physical effort - .40; mental effort and judgement - .40; iatrogenic risk - .10; and quality control and quality assurance - .10.

AMERICAN COLLEGE OF RADIOLOGY
RELATIVE VALUE STUDY

Worksheet
(continued)

PROCEDURE		RELATIVE VALUE based on:			
CPT-4 Code	Description	Charge Survey (pilot)	Critical Factors: Wght.Avg.*	(2)/(1)	
THE STANDARD: 74400	Intravenous urography, pyelography, with or without KUB	(1) 100	(2) 100	(3) 1.00	(4) 100
93870	Non-invasive studies of carotid artery, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution b-scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis)	205	185	.90	
73581	Knee arthrography exam; complete	244	245	1.00	
70470	Head CT; without contrast material followed by contrast material(s) and further sections	251	150	.60	
72131	Computerized axial tomography, lumbar spine; without contrast material	283	158	.56	
74160	Abdomen CT; with contrast	287	185	.64	
70551	MR (e.g., proton) imaging, brain (including brain stem)	378	170	.45	
74321	Complete cholangiography, percutaneous, transhepatic	396	480	1.21	
71037	Needle biopsy of intrathoracic lesion, including follow-up films; complete procedure	631	450	.71	
75990	Drainage of abscess, percutaneous, with radiologic guidance (i.e., fluoroscopy, ultrasound, or computed tomography); with or without placement of indwelling catheter	701	450	.64	
75657	Cervicocerebral angiography, including vessel origin, selective catheter; 3 or 4 vessels, complete	946	820	.87	
75963	Percutaneous transluminal angioplasty, peripheral artery; complete procedure	1,622	860	.53	

The values for this scale represent a weighted average of pilot survey responses for 4 critical factors, using weights as follows:

technical skill and physical effort - .40; mental effort and judgement - .40; iatrogenic risk - .10; and quality control and quality assurance - .10.

AMERICAN COLLEGE OF RADIOLOGY
RELATIVE VALUE STUDY

Worksheet

PROCEDURE		RELATIVE VALUE based on:			
CPT-4 Code	Description	Charge Survey (pilot)	Time	(2)/(1)	
THE STANDARD: 74400	Intravenous urography, pyelography, with or without KUB	(1) 100	(2) 100	(3) 1.00	(4) 100
73630	Complete foot exam; min 3 views	34	20	.58	
71020	Two view chest exam frontal and lateral	40	27	.67	
73510	Complete hip exam; min. 2 views	43	27	.62	
70220	Sinuses exam complete, paranasal, min 3 views	54	20	.37	
74020	Complete abdomen exam including decubitus and/or erect views	56	27	.48	
72110	Complete spine exam, lumbosacral with oblique views	63	33	.53	
76091	Bilateral mammography	77	60	.77	
78006	Thyroid imaging, with uptake; single determination	119	33	.28	
76805	Echography, pregnant uterus, b-scan and/or real time with image documentation; complete	122	133	1.10	
74280	Colon exam; air contrast with specific high density barium, with or without glucagon	132	167	1.26	
78585	Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath	159	53	.34	
78215	Liver and spleen imaging; static only	173	33	.19	
78305	Bone imaging; multiple areas	173	67	.39	
78471	Cardiac blood pool imaging, gated equilibrium, at rest, wall motion study plus ejection fraction	200	90	.45	

AMERICAN COLLEGE OF RADIOLOGY
RELATIVE VALUE STUDY

Worksheet
(continued)

PROCEDURE		RELATIVE VALUE based on:			
CPT-4 Code	Description	Charge Survey (pilot)	Time	(2)/(1)	
THE STANDARD: 74400	Intravenous urography, pyelography, with or without KUB	(1) 100	(2) 100	(3) 1.00	(4) 100
93870	Non-invasive studies of carotid artery, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution b-scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis)	205	133	.65	
73581	Knee arthrography exam; complete	244	200	.81	
70470	Head CT; without contrast material followed by contrast material(s) and further sections	251	73	.29	
72131	Computerized axial tomography, lumbar spine; without contrast material	283	100	.35	
74160	Abdomen CT; with contrast	287	117	.41	
70551	MR (e.g., proton) imaging, brain (including brain stem)	378	100	.26	
74321	Complete cholangiography, percutaneous, transhepatic	396	400	1.01	
71037	Needle biopsy of intrathoracic lesion, including follow-up films; complete procedure	631	300	.48	
75990	Drainage of abscess, percutaneous, with radiologic guidance (i.e., fluoroscopy, ultrasound, or computed tomography); with or without placement of indwelling catheter	701	433	.62	
75657	Cervicocerebral angiography, including vessel origin, selective catheter; 3 or 4 vessels, complete	946	800	.85	
75963	Percutaneous transluminal angioplasty, peripheral artery; complete procedure	1,622	600	.37	

AMERICAN COLLEGE OF RADIOLOGY
RELATIVE VALUE STUDY

Pilot Survey Medians
Charges and Critical Factors

PROCEDURE		RELATIVE VALUE based on:					
CPT-4 Code	Description	Charge Survey (pilot)	Mental Effort	Technical Skill	QC-QA	Harm	Complexity
THE STANDARD: 74400	Intravenous urography, pyelography, with or without KUB	(1) 100	(2) 100	(3) 100	(4) 100	(5) 100	(6) 100
73630	Complete foot exam; min 3 views	34	50	20	50	20	30
71020	Two view chest exam frontal and lateral	40	30	20	50	20	50
73510	Complete hip exam; min. 2 views	43	50	30	50	30	50
70220	Sinuses exam complete, paranasal, min 3 views	54	50	20	50	20	40
74020	Complete abdomen exam including decubitus and/or erect views	56	50	30	50	20	50
72110	Complete spine exam, lumbosacral with oblique views	63	50	40	50	25	50
76091	Bilateral mammography	77	100	50	150	50	100
78006	Thyroid imaging, with uptake; single determination	119	80	70	100	28	80
76805	Echography, pregnant uterus, b-scan and/or real time with image documentation; complete	122	225	200	225	65	200
74280	Colon exam; air contrast with specific high density barium, with or without glucagon	132	300	300	200	100	275

AMERICAN COLLEGE OF RADIOLOGY
RELATIVE VALUE STUDY

Pilot Survey Medians
Charges and Critical Factors
(continued)

PROCEDURE		RELATIVE VALUE based on:					
CPT-4 Code	Description	Charge Survey (pilot)	Mental Effort	Technical Skill	QC-QA	Harm	Complexity
THE STANDARD: 74400	Intravenous urography, pyelography, with or without KUB	(1) 100	(2) 100	(3) 100	(4) 100	(5) 100	(6) 100
78585	Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath	159	150	100	150	100	100
78215	Liver and spleen imaging; static only	173	100	100	100	50	100
78305	Bone imaging; multiple areas	173	100	70	100	50	90
78471	Cardiac blood pool imaging, gated equilibrium, at rest, wall motion study plus ejection fraction	200	200	100	150	100	150
93870	Non-invasive studies of carotid artery, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution b-scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis)	205	200	200	200	50	175
73581	Knee arthrography exam; complete	244	250	300	150	100	238
70470	Head CT; without contrast material followed by contrast material(s) and further sections	251	200	100	200	100	200

AMERICAN COLLEGE OF RADIOLOGY
RELATIVE VALUE STUDY

Pilot Survey Medians
Charges and Critical Factors
(continued)

PROCEDURE		RELATIVE VALUE based on:					
CPT-4 Code	Description	Charge Survey (pilot)	Mental Effort	Technical Skill	QC-QA	Harm	Complexity
THE STANDARD:		(1)	(2)	(3)	(4)	(5)	(6)
74400	Intravenous urography, pyelography, with or without KUB	100	100	100	100	100	100
72131	Computerized axial tomography, lumbar spine; without contrast material	283	275	78	200	78	200
74160	Abdomen CT; with contrast	287	250	100	200	100	225
70551	MR (e.g., proton) imaging, brain (including brain stem)	378	275	100	250	50	200
74321	Complete cholangiography, percutaneous, transhepatic	396	500	500	350	400	400
71037	Needle biopsy of intrathoracic lesion, including follow-up films; complete procedure	631	400	500	300	400	400
75990	Drainage of abscess, percutaneous, with radiologic guidance (i.e., fluoroscopy, ultrasound, or computed tomography); with or without placement of indwelling catheter	701	500	500	300	350	500
75657	Cervicocerebral angiography, including vessel origin, selective catheter; 3 or 4 vessels, complete	946	800	800	500	800	800
75963	Percutaneous transluminal angioplasty, peripheral artery; complete procedure	1,622	1,000	800	500	500	700

WORK INVOLVED IN THE INTERPRETATION OF A RADIOGRAPHIC EXAMINATION BY A RADIOLOGIST

The following steps are involved in the interpretation of a radiographic examination by a radiologist and in the communication of the results to the referring physician:

1. **EVALUATION OF THE QUALITY OF THE FILMS.**
The radiologist is responsible for the supervision of the technologist who performs the examination. The films are critiqued for appropriate technique (exposure, correct views, positioning, degree of inspiration, labeling).
2. **EVALUATION OF ALL ANATOMY ON THE FILMS, NOT JUST THE AREA OF CLINICAL INTEREST.**
For example, a radiologist makes numerous observations when evaluating a PA and lateral chest exam, including soft tissues, bony structures, diaphragms, mediastinum, cardiovascular structures, and lungs/pleura.
3. **REVIEW OF PRIOR REPORTS, WHEN APPROPRIATE.**
4. **COMPARISON OF CURRENT EXAMINATION WITH PREVIOUS EXAMINATIONS OF THE SAME AREA, WHEN APPROPRIATE.**
5. **CORRELATION OF FINDINGS ON CURRENT EXAM WITH THOSE FROM OTHER IMAGING STUDIES, WHEN APPROPRIATE.**
6. **REEVALUATION OF OBSERVATIONS AND DETERMINATION OF THE SIGNIFICANCE OF ANY VARIATIONS FROM THE NORM.**
7. **PREPARATION AND DICTATION OF A REPORT IN COMPLIANCE WITH THE ACR STANDARD ON COMMUNICATION.**
A precise diagnosis should be given whenever possible and a differential diagnosis when appropriate.

Recommendations for follow-up and additional diagnostic studies to clarify or confirm one's impression should be given when appropriate.
8. **IMMEDIATE COMMUNICATION OF RESULTS TO THE REFERRING PHYSICIAN WHEN APPROPRIATE (e.g., UNUSUAL, UNEXPECTED, OR URGENT FINDINGS WHICH MAY REQUIRE IMMEDIATE CASE MANAGEMENT DECISIONS).**
9. **PROOFREADING AND AUTHENTICATION OF FINAL WRITTEN REPORT.**
10. **"SECOND-LOOK" CONSULTATIONS WITH REFERRING PHYSICIAN OR WITH OTHER PHYSICIANS INVOLVED IN THE CARE OF THE PATIENT.**

Attachment 3

The following table illustrates the point that the number of images depends on the anatomic site and contrast usage: (Please note – the number of images interpreted varies according to the protocol used at the institution and the clinical question to answer.)

Number of Images: MR

Anatomic Site (CPT Codes)	Without Contrast (If applicable)	With Contrast (If applicable)	Without and With Contrast (If applicable)
Temporomandibular Joint (code 70336)	48	N/A	N/A
Brain (codes 70551-70553)	80	80	120
Cervical Spine (codes 72141, 72142, 72156)	45	45	70
Thoracic Spine (codes 72146, 72147, 72157)	45	45	70
Lumbar Spine (codes 72148, 72149, 72158)	45	45	70
Pelvis (code 72196)	80	N/A	N/A
Upper Extremity (code 73220)	80	N/A	N/A
Upper Extremity, Joint (code 73221)	80	N/A	N/A
MRA Upper Extremity (code 73225)	200 (raw data)	200 (raw data)	N/A
Upper Extremity (code 73720)	80	N/A	N/A
Upper Extremity, Joint (code 73721)	80	N/A	N/A
Abdomen (code 74181)	90-100	N/A	N/A
Myocardium (code 75552)	100	N/A	N/A
Myocardium (code 75553)	N/A	140	N/A
Cardiac Function (code 75554)	300		
Cardiac Function (code 75555)	200		
Cardiac Flow Mapping (code 75556)	200		
Bone Marrow (code 76400)	90		

Attachment 4

The following table illustrates the point that the number of images depends on the anatomic site and contrast usage: (Please note -- the number of images interpreted varies according to the protocol used at the institution and the clinical question to answer.)

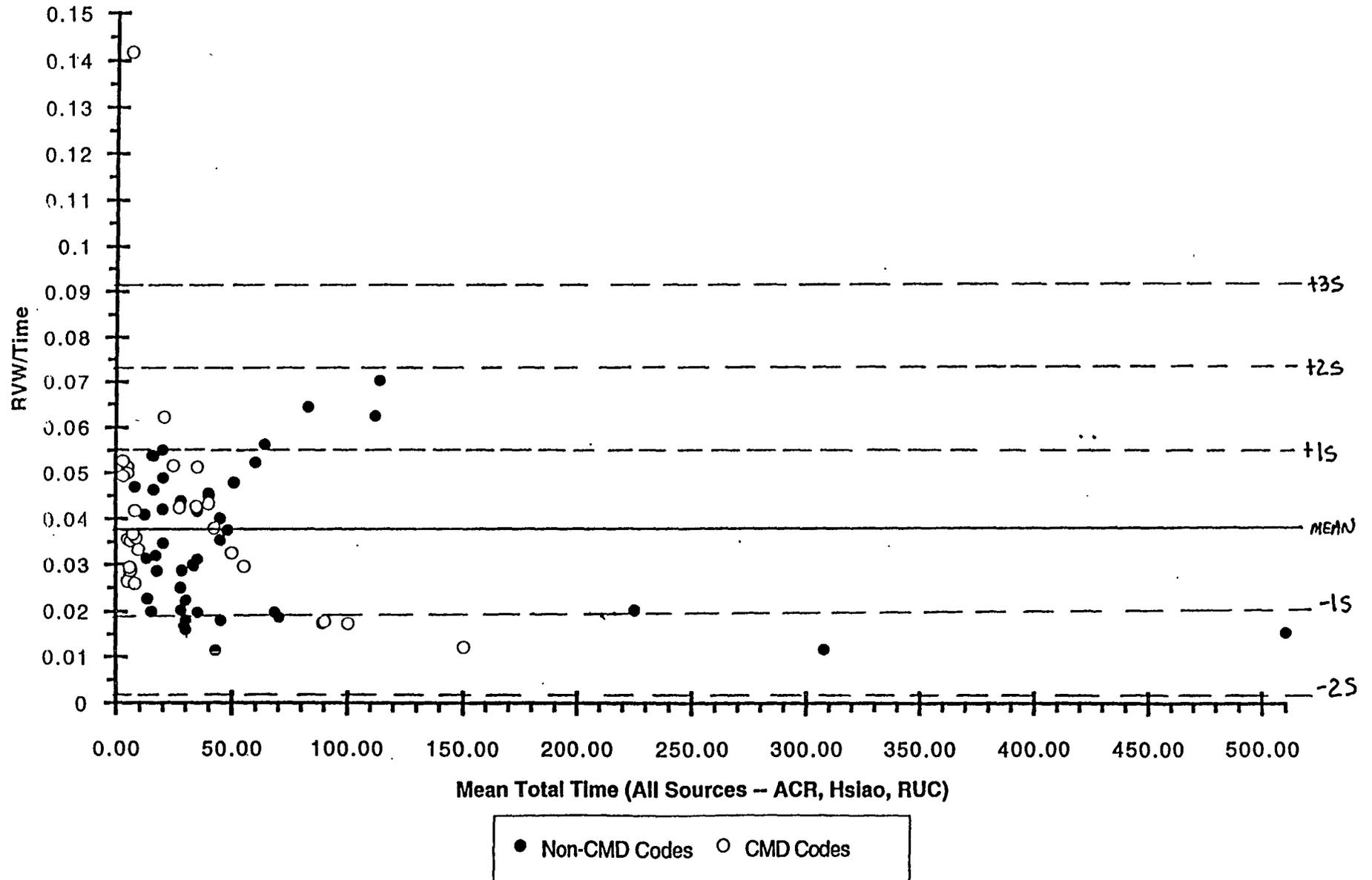
Number of Images: CT

Anatomic Site (CPT Codes)	Without Contrast (If applicable)	With Contrast (If applicable)	Without and With Contrast (If applicable)
Brain (codes 70450-70470)	17	17	34
Skull (codes 70480-70482)	28	28	56
Face (codes 70486-70488)	40	40	80
Neck (codes 70490-70492)	25	25	50
Chest (codes 71250-71270)	35	35	70
Cervical Spine (codes 72125-72127)	25	25	50
Thoracic Spine (codes 72128-72130)	40	40	80
Lumbar Spine (codes 72131-72133)	30	30	60
Pelvis (codes 72192-72194)	30	30	60
Upper Extremity (codes 73200-73202)	50	50	100
Lower Extremity (codes 73700-73702)	50	50	100
Abdomen (codes 74150-74170)	40	40	80
Localization (code 76355)	30	N/A	N/A
Biopsy (code 76360)	30	N/A	N/A
Cyst Aspiration (code 76365)	20	N/A	N/A
Radiation Oncology (code 76370)	30	N/A	N/A
Limited / Follow-up (code 76380)	20	N/A	N/A

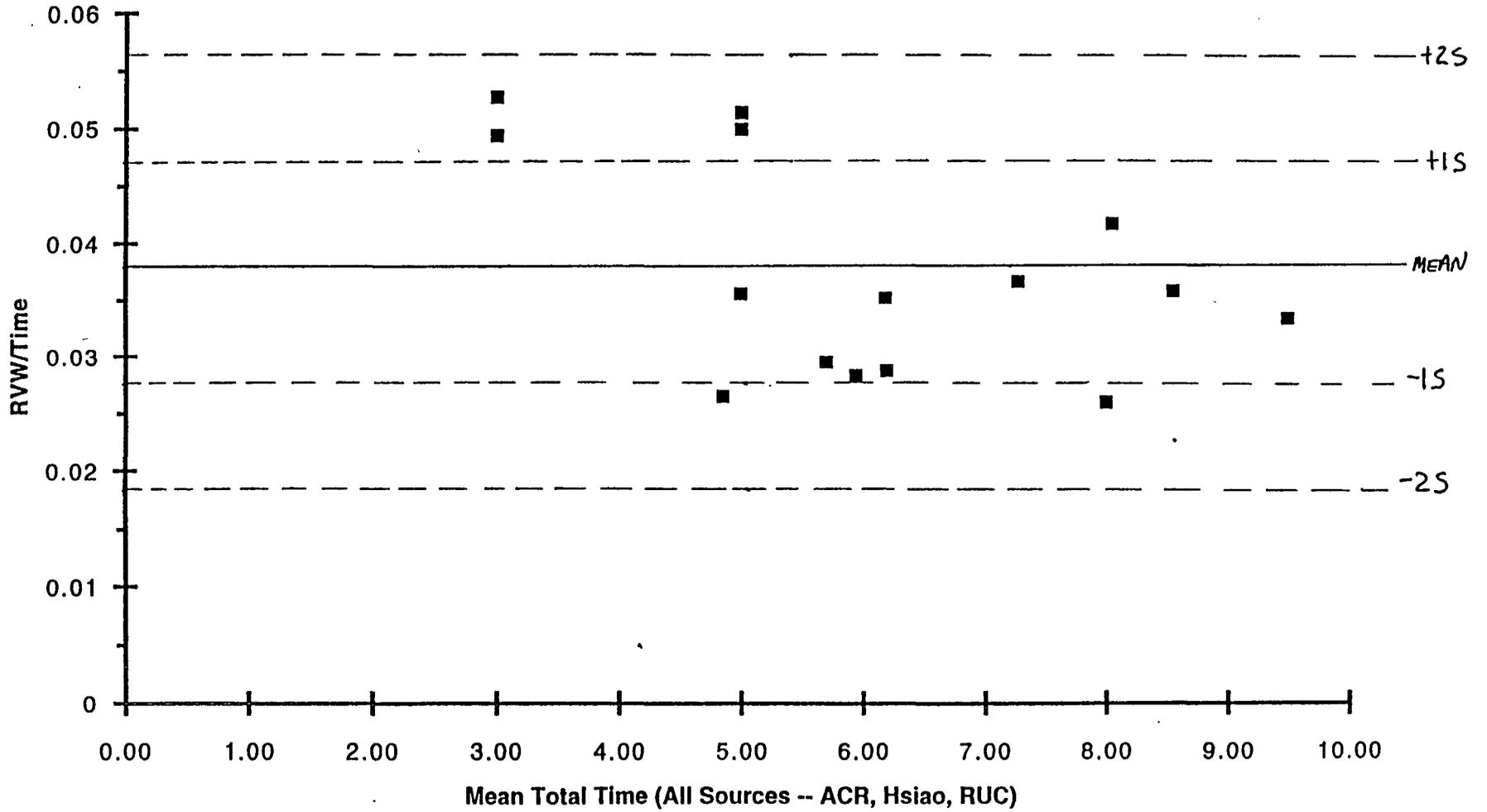
Mean RVW/Time = 0.037; Std = 0.018

Attachment 5

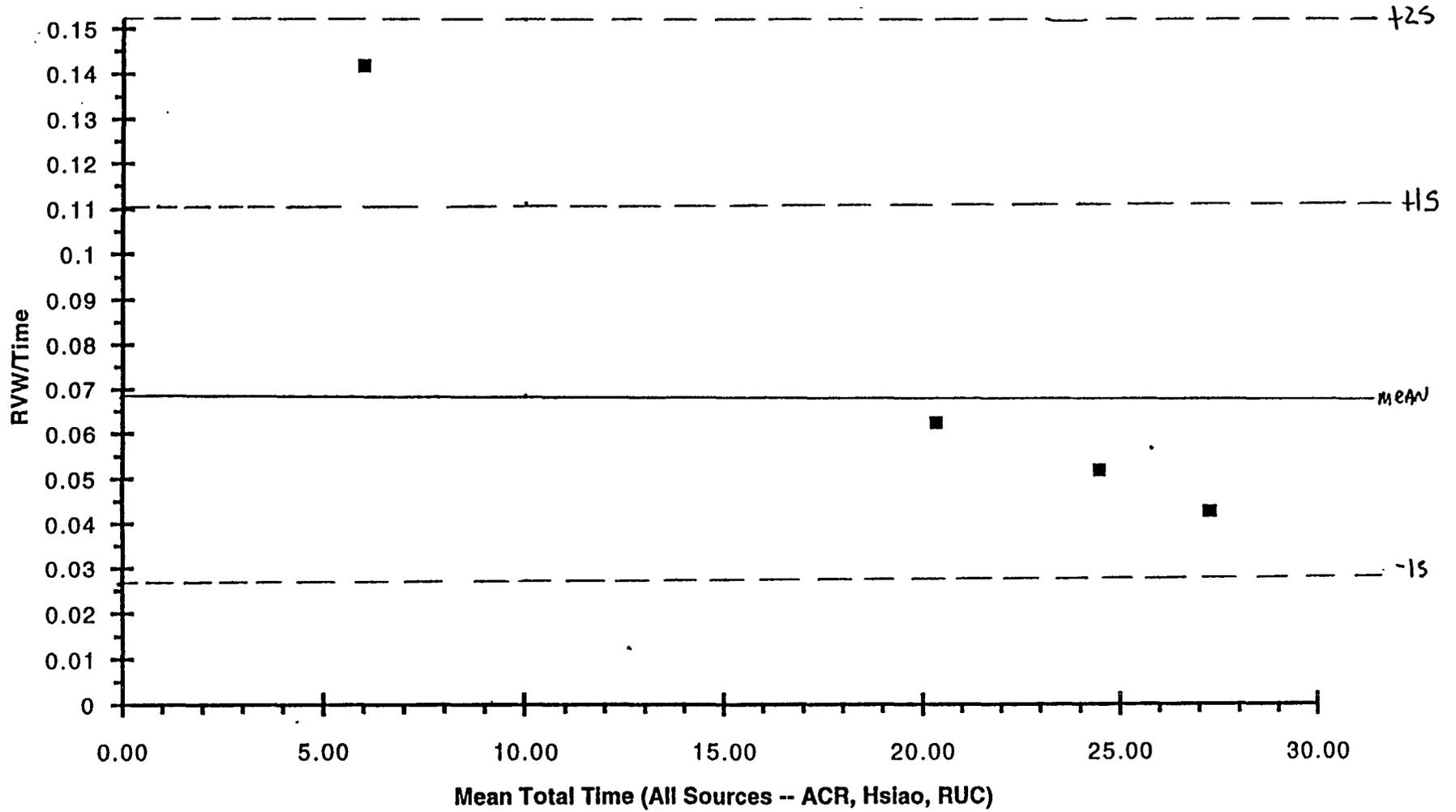
RVW/Time For Radiology



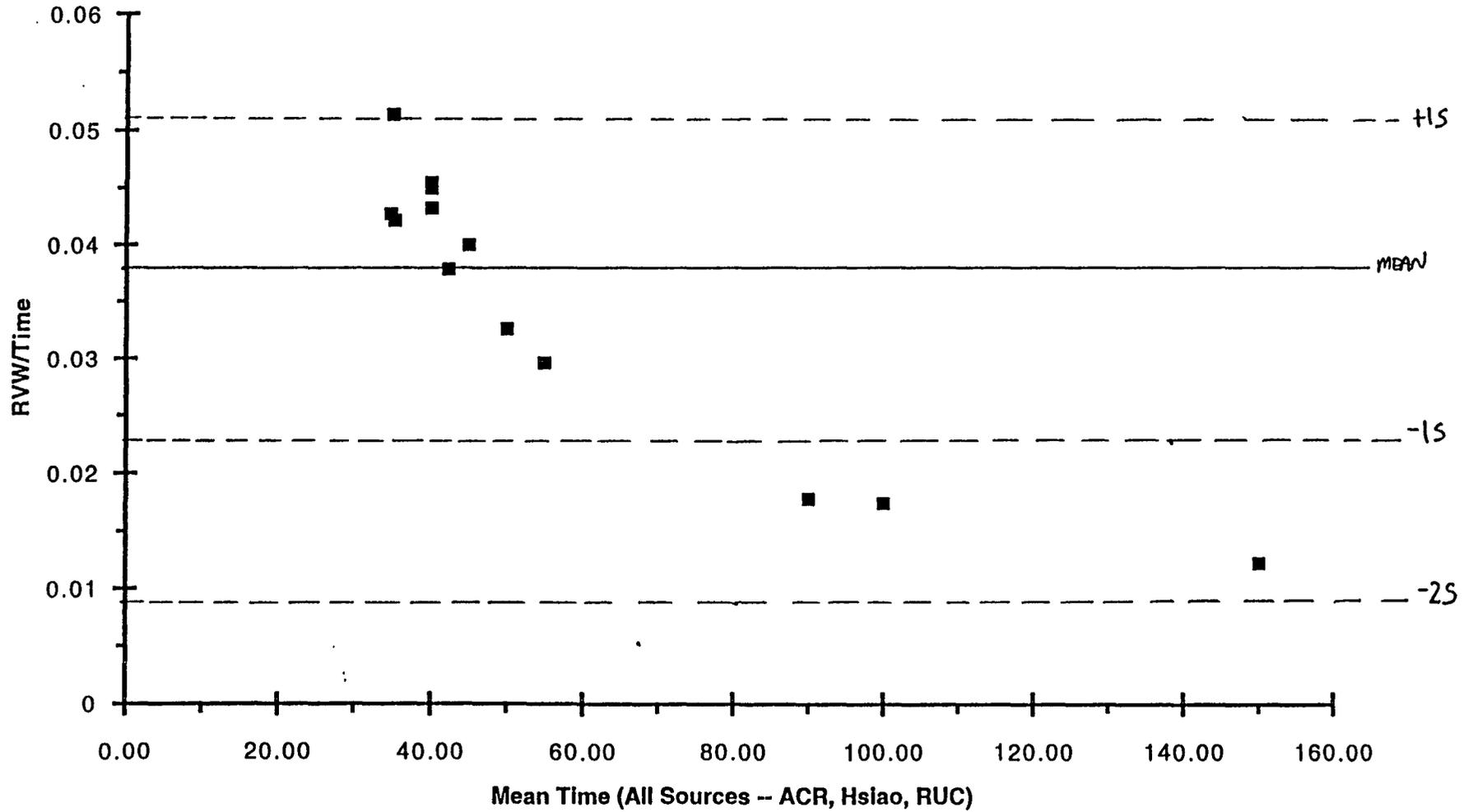
RVW/Time for Plain Film Studies



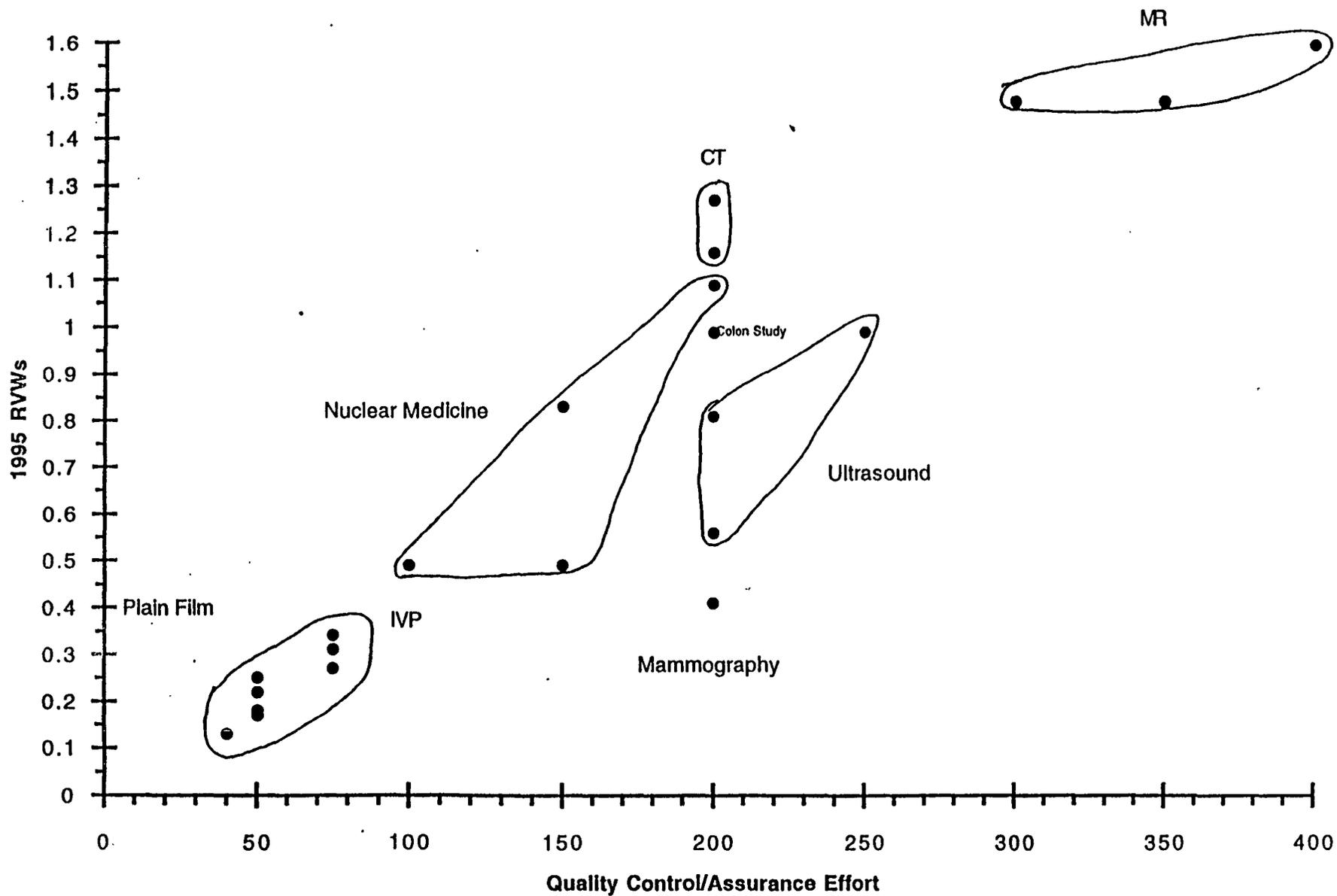
RVW/Time For CT



RVW/Time For MRI



Quality Control/Assurance Effort vs Radiology RVWs



CODE	Time in Minutes									
	1995	MEAN	MEDIAN	MEDIAN	HSIAO I	HSIAO 4	Mean Time	RVW/Mean	Median Time	RVW/Median
	RVW	RADIOLOGY RVS	RADIOLOGY RVS	FUC	TOTAL	TOTAL	All sources	Time	All Sources	Time
70150	0.28					5	5.00	0.051428	5	0.051428
70220	0.25		5				5.00	0.05	5	0.05
70260	0.34	10.56	5		8.8		8.05	0.04175414	8.8	0.0391
70450	0.85					8	6.00	0.14175867	8	0.14175867
70470	1.27	33.06	20			8	20.35	0.06219718	20	0.063298
70541	1.81			40			40.00	0.04524675	40	0.04524675
70551	1.48	49.41	20				34.71	0.042746	34.705	0.042746
71010	0.18					5	5.00	0.035604	5	0.035604
71020	0.22	8.32	5		6.4	5	6.18	0.03520712	5.7	0.03817193
71111	0.32				9.5		9.50	0.03331368	9.5	0.03331368
71250	1.16	34.50	20				27.25	0.04246349	27.25	0.04246349
71550	1.60	54.55	30				42.28	0.03789899	42.275	0.03789899
71555	1.81			40			40.00	0.04524675	40	0.04524675
72020	0.15					3	3.00	0.04945	3	0.04945
72110	0.31	10.87	5		9.8		8.58	0.03583054	9.8	0.03128469
72131	1.16	34.60	20				27.30	0.04238571	27.3	0.04238571
72148	1.48	50.33	20				35.17	0.04218683	35.165	0.04218683
72159	1.80			45			45.00	0.03999958	45	0.03999958
72198	1.80			35			35.00	0.051428	35	0.051428
73110	0.17	6.88	5				5.94	0.02830471	5.94	0.02830471
73140	0.13	6.70	3				4.85	0.02650928	4.85	0.02650928
73225	1.73			40			40.00	0.04326875	40	0.04326875
73510	0.21				8		8.00	0.02596125	8	0.02596125
73682	0.18	7.39	5				6.20	0.02873608	6.195	0.02873608
73610	0.17				5.7		5.70	0.02949649	5.7	0.02949649
73620	0.16					3	3.00	0.05274667	3	0.05274667
73725	1.82			40			40.00	0.045494	40	0.045494
74020	0.27	9.80	5		9.3	5	7.28	0.03670515	7.15	0.03734685
74160	1.27	38.21	20		24.8	15	24.50	0.05166493	22.4	0.05651429
74185	1.80			40			40.00	0.0449995	40	0.0449995
74190	0.48			30			30.00	0.016	30	0.016
74247	0.69	35.18	20		27.8		27.86	0.02502892	27.8	0.02490288
74251	0.69			35			35.00	0.01971429	35	0.01971429
74280	0.99	44.55	25		39.2	24	33.19	0.02960038	32.1	0.03080997
74340	0.54			30			30.00	0.01813167	30	0.01813167
74400	0.49				35.8	23	29.40	0.01681973	29.4	0.01681973
74740	0.38					8	8.00	0.0469775	8	0.0469775
75552	1.60			90			90.00	0.017802	90	0.017802
75554	1.83			150			150.00	0.01219767	150	0.01219767
75555	1.74			100			100.00	0.0174064	100	0.0174064
75900	0.49			43.00			43.00	0.01139535	43	0.01139535
76075	0.30			15			15.00	0.02	15	0.02

CODE	Time In Minutes									
	1995	MEAN	MEDIAN	MEDIAN	HSIAO 1	HSIAO 4	Mean Time	RVW/Mean	Median Time	RVW/Median
	RVW	RADIOLOGY RVS	RADIOLOGY RVS	RJC	TOTAL	TOTAL	All sources	Time	All Sources	Time
78091	0.41	18.32	10		15.4	8	12.93	0.0313604	12.7	0.03192835
78093	1.83			50.00			50.00	0.0328	50	0.0328
78094	1.83			55.00			55.00	0.02983836	55	0.02983836
78095	1.59			45			45.00	0.03538422	45	0.03538422
76516	0.64					17	17.00	0.03199706	17	0.03199706
76536	0.56	35.74	20				27.87	0.02022713	27.87	0.02022713
76700	0.81	33.78	15		40.1	24	28.22	0.02874287	28.88	0.02808102
76805	0.99	38.84	20		40.2	33	33.01	0.02998082	35.92	0.02753341
76872	0.69					20	20.00	0.034815	20	0.034815
76938	1.31			70			70.00	0.01871429	70	0.01871429
76941	1.34			68			68.00	0.01970588	68	0.01970588
76945	0.67			30			30.00	0.02233333	30	0.02233333
76976	0.81			45			45.00	0.01802178	45	0.01802178
77283	3.14					60	60.00	0.05233333	60	0.05233333
77290	1.56					89	89.00	0.01752809	89	0.01752809
77295	4.57			225			225.00	0.02030747	225	0.02030747
77419	3.60			307.5			307.50	0.01170719	307.5	0.01170719
77425	2.44					51	51.00	0.04789863	51	0.04789863
77430	3.60					64	64.00	0.05625	64	0.05625
77432	7.93			510			510.00	0.01555251	510	0.01555251
77762	5.35					83	83.00	0.06445783	83	0.06445783
77763	8.01				113.9		113.90	0.07033275	113.9	0.07033275
77777	6.99					112	112.00	0.06241071	112	0.06241071
78006	0.49	18.72	10			23	17.24	0.02868329	18.72	0.0284158
78215	0.49	14.20	10				12.10	0.04086777	12.1	0.04086777
78223	0.84					20	20.00	0.042	20	0.042
78305	0.83	20.85	10				15.43	0.05385802	15.425	0.05385802
78306	0.86					16	16.00	0.05377688	16	0.05377688
78351	0.30			15	11.4		13.20	0.02272727	13.2	0.02272727
78461	1.23					28	28.00	0.04379857	28	0.04379857
78465	1.46					35	35.00	0.04171429	35	0.04171429
78472	0.98					20	20.00	0.0489555	20	0.0489555
78580	0.74					16	16.00	0.04635938	16	0.04635938
78585	1.09	26.35	10			23	19.78	0.05499073	23	0.0473
78807	1.09			35			35.00	0.03108286	35	0.03108286
79000	1.80					48	48.00	0.03749958	48	0.03749958
							mean	0.03730379		0.03718531
							std	0.01841285		0.01844748

UNIVARIATE ON TECH ALL AND PHYSICAL EFFORT
 CRIT/UNIVO4: ADDED 20TH 80TH PERCENTILES AND RATIOS
 (USED SAS DEFINITION #2, FOR PERCENTILES)

10:52 WEDNESDAY, DECEMBER 1988

OBS	CPT	N	MEAN	MEDIAN	MIN	P10	P20	Q1	Q3	P80	P90	MAX	QRANGE	RT9010	RT8020	STD	COEFV	SKEWNESS
1	47630	414	1426.32	1000	100	350	500	600	1500	2000	2500	20000	900	7.143	4.000	1861.33	130.499	6.090
2	70220	928	38.54	25	0	1	10	10	50	50	80	400	40	80.000	5.000	36.91	95.771	2.705
3	70260	452	61.23	50	0	10	20	25	80	100	100	1000	55	10.000	5.000	68.67	112.164	6.836
4	70470	445	186.82	150	0	80	100	100	200	250	300	1500	100	3.750	2.500	166.22	88.976	3.740
5	70551	410	232.69	150	0	5	40	50	300	300	500	10000	250	100.000	7.500	536.23	230.452	15.030
6	71020	926	36.77	25	0	1	10	10	50	50	80	200	40	80.000	5.000	31.61	85.965	1.419
7	71037	437	775.19	500	125	250	300	340	1000	1000	1400	10000	660	5.600	3.333	924.88	119.309	5.449
8	71250	444	171.89	100	0	10	50	50	200	250	325	2000	150	32.500	5.000	201.93	117.472	4.071
9	71550	803	250.57	150	0	10	50	50	300	350	500	6000	250	50.000	7.000	393.51	157.047	7.383
10	72110	476	49.45	40	0	0	10	12	75	80	100	750	63	.	8.000	53.38	107.943	5.451
11	72131	444	187.20	125	0	10	50	50	200	300	400	3000	150	40.000	6.000	244.69	130.709	5.468
12	72144	410	215.89	150	0	5	50	50	300	300	500	2000	250	100.000	6.000	246.41	114.138	2.849
13	72266	912	632.36	400	10	200	250	300	700	800	1000	20000	400	5.000	3.200	1050.33	166.098	10.570
14	73110	476	31.86	25	0	0	10	10	50	50	75	300	40	.	5.000	31.19	97.900	2.642
15	73140	476	26.01	20	0	0	5	10	40	50	50	150	30	.	10.000	24.06	92.525	1.594
16	73562	476	35.27	25	0	0	10	10	50	50	75	900	40	.	5.000	49.59	140.598	11.510
17	74020	929	46.93	40	0	5	10	20	50	75	100	1000	30	20.000	7.500	52.85	112.604	7.804
18	74160	911	191.39	150	0	50	100	100	200	250	400	2000	100	8.000	2.500	181.84	95.011	3.935
19	74247	923	294.47	250	40	130	150	200	300	400	500	3000	100	3.846	2.667	234.96	79.790	5.385
20	74280	453	322.37	250	50	150	175	200	400	400	500	4000	200	3.333	2.286	286.10	88.748	7.026
21	74476	449	1385.57	800	60	300	400	500	1400	1500	2000	50000	900	6.667	3.750	3206.56	231.425	10.327
22	74741	442	325.60	250	0	100	150	180	400	400	500	7000	220	5.000	2.667	397.18	121.984	11.307
23	75631	440	965.25	750	120	300	350	400	1000	1200	1800	12000	600	6.000	3.429	1114.64	115.477	5.229
24	75655	458	1658.81	1000	10	350	500	500	1500	2000	2500	50000	1000	7.143	4.000	3725.45	224.586	8.958
25	75673	899	1532.91	1000	100	400	500	600	1500	2000	2300	40000	900	5.750	4.000	2564.41	167.291	8.592
26	75727	439	1115.25	900	100	300	400	500	1200	1500	2000	18000	700	6.667	3.750	1321.83	118.523	6.642
27	75742	451	1219.00	750	100	300	400	500	1000	1500	2000	30000	500	6.667	3.750	2273.95	186.542	7.865
28	75754	337	1049.30	600	0	110	200	300	1180	1500	2000	18000	880	18.182	7.500	1605.69	153.024	6.123
29	75755	707	1632.08	1000	4	400	500	600	1500	2000	2500	50000	900	6.250	4.000	3597.95	220.452	9.987
30	75808	443	1425.53	800	4	300	400	450	1500	1800	2500	35000	1050	8.333	4.500	2918.39	204.724	8.213
31	75821	471	309.21	250	70	100	150	190	300	400	500	5200	110	5.000	2.667	357.31	115.553	8.609
32	75963	414	1594.06	1000	100	400	500	600	2000	2000	3000	25000	1400	7.500	4.000	2064.85	129.534	6.294
33	75983	450	1801.27	1000	100	350	500	500	2000	2000	3000	60000	1500	8.571	4.000	4285.56	237.919	9.818
34	75990	460	1158.20	600	25	250	300	400	1000	1200	2000	30000	600	8.000	4.000	2350.79	202.970	7.591
35	76091	921	107.50	80	0	10	25	30	125	150	200	2500	95	20.000	6.000	148.41	138.060	7.956
36	76361	895	832.85	500	0	200	300	300	1000	1000	1500	20000	700	7.500	3.333	1397.45	167.790	8.365
37	76536	432	286.33	200	0	90	100	150	300	350	500	9000	150	5.556	3.500	478.25	167.026	14.429
38	76700	461	291.17	200	0	100	110	150	300	350	500	8000	150	5.000	3.182	427.89	146.954	13.302
39	76805	894	337.59	250	0	100	150	150	400	500	500	15000	250	5.000	3.333	611.26	181.063	17.288
40	78006	430	110.45	100	0	20	50	50	150	150	200	500	100	10.000	3.000	89.86	81.359	1.911
41	78215	430	86.50	100	0	10	30	50	100	100	150	500	50	15.000	3.333	66.63	77.029	2.170
42	78305	458	100.48	100	0	10	30	50	110	150	200	600	60	20.000	5.000	82.57	82.175	1.716
43	78471	814	192.57	150	0	30	90	100	200	250	350	5000	100	11.667	2.778	264.71	137.461	10.030
44	78585	876	137.63	100	0	20	50	50	200	200	300	2000	150	15.000	4.000	144.84	105.235	4.596
45	93870	826	367.18	250	0	100	150	150	400	500	600	15000	250	6.000	3.333	685.43	186.677	14.751

UNIVARIATE ON MENTAL EFFORT AND JUDGMENT
 CRIT/UNIVO4; ADDED 20TH BOTH PERCENTILES AND RATIOS
 (USED SAS DEFINITION #2, FOR PERCENTILES)

10:52 WEDNESDAY, DECEMBER 7, 1988 1

OBS	CPT	N	MEAN	MEDIAN	MIN	P10	P20	Q1	Q3	P80	P90	MAX	ORANGE	RT9010	RT8020	STD	COEFV	SKEWNESS
1	47630	413	1032.42	750	50	275	400	400	1200	1250	2000	20000	800	7.273	3.125	1358.37	131.572	8.111
2	70220	929	62.13	50	5	25	30	33	75	80	100	1100	42	4.000	2.667	65.62	105.603	9.599
3	70260	454	100.85	80	20	50	50	50	100	100	200	1000	50	4.000	2.000	86.59	85.856	4.653
4	70470	446	271.00	200	50	100	150	150	300	300	400	5000	150	4.000	2.000	296.38	109.367	10.061
5	70551	410	456.35	300	33	175	200	200	500	500	800	10000	300	4.571	2.500	664.44	145.600	9.741
6	71020	929	57.79	50	10	25	30	30	75	75	100	1000	45	4.000	2.500	52.24	90.386	9.257
7	71037	435	543.45	400	50	200	250	300	600	700	1000	5000	300	5.000	2.800	511.34	94.091	4.363
8	71250	445	318.25	250	75	125	150	200	300	400	500	6000	100	4.000	2.667	383.24	120.421	9.149
9	71550	805	537.24	400	75	200	200	250	600	700	1000	20000	350	5.000	3.500	895.80	166.740	14.915
10	72110	476	80.19	75	15	35	50	50	100	100	100	1000	50	2.857	2.000	72.07	89.871	9.195
11	72131	445	330.48	250	50	125	190	200	350	400	500	5000	150	4.000	2.105	333.23	100.834	7.535
12	72144	411	435.97	300	10	150	200	200	500	500	800	10000	300	5.333	2.500	624.32	143.201	10.409
13	72265	913	484.44	350	40	150	200	200	500	600	800	20000	300	5.333	3.000	847.37	174.917	15.110
14	73110	475	45.50	40	5	20	25	25	50	60	75	200	25	3.750	2.400	26.26	57.712	1.744
15	73140	476	32.00	25	5	10	18	20	50	50	50	200	30	5.000	2.778	20.40	63.739	2.145
16	73562	475	48.50	50	8	20	25	25	50	70	80	300	25	4.000	2.800	29.91	61.675	2.691
17	74020	929	66.95	50	10	25	40	50	80	100	100	1000	30	4.000	2.500	50.11	74.847	8.774
18	74160	911	346.29	250	50	125	175	200	400	400	500	20000	200	4.000	2.286	751.78	217.096	21.455
19	74247	925	221.77	200	40	100	120	130	250	300	300	5000	120	3.000	2.500	220.03	99.213	12.666
20	74280	453	239.17	200	50	100	140	150	300	300	400	2000	150	4.000	2.143	170.07	71.109	4.352
21	74476	447	1033.32	600	25	250	350	370	1000	1100	2000	20000	630	8.000	3.143	1873.66	181.325	7.330
22	74741	446	218.05	175	20	100	100	100	250	300	400	3000	150	4.000	3.000	210.22	96.408	6.600
23	75631	440	735.14	500	100	200	300	300	1000	1000	1200	15000	700	6.000	3.333	978.52	133.107	9.084
24	75655	457	1232.19	900	100	300	400	500	1200	1500	2000	40000	700	6.667	3.750	2466.88	200.203	11.061
25	75673	902	1191.04	1000	0	300	500	500	1100	1500	2000	50000	600	6.667	3.000	2478.20	208.070	14.873
26	75727	439	912.93	700	125	300	400	400	1000	1000	1700	20000	600	5.667	2.500	1209.44	132.480	10.188
27	75742	449	972.56	600	100	250	300	400	1000	1000	1500	50000	600	6.000	3.333	2678.70	275.427	14.856
28	75754	334	869.63	500	100	200	300	300	1000	1200	1750	8500	700	8.750	4.000	1031.76	118.644	3.687
29	75755	691	1280.18	1000	6	300	500	500	1250	1500	2000	50000	750	6.667	3.000	2731.34	213.357	13.215
30	75808	443	882.47	500	5	200	250	300	1000	1000	1500	30000	700	7.500	4.000	1785.95	202.382	11.169
31	75821	471	239.01	200	25	100	110	150	300	300	400	5000	150	4.000	2.727	262.14	109.676	13.127
32	75963	414	1260.48	900	100	300	400	500	1500	1500	2000	25000	1000	6.667	3.750	1854.65	147.138	8.222
33	75983	448	1303.79	800	33	300	400	500	1300	1500	2250	50000	800	7.500	3.750	3004.64	230.454	12.005
34	75990	456	777.59	500	20	200	300	300	1000	1000	1500	20000	700	7.500	3.333	1351.17	173.765	10.337
35	76091	920	147.92	100	1	50	75	75	200	200	300	2000	125	6.000	2.667	142.86	96.581	4.939
36	76361	894	605.56	450	33	200	250	300	700	800	1000	20000	400	5.000	3.200	909.22	150.147	13.713
37	76536	439	239.23	200	50	100	100	125	300	300	400	2000	175	4.000	3.000	205.09	85.730	3.957
38	76700	462	218.74	200	38	100	100	130	300	300	350	1500	170	3.500	3.000	139.54	63.791	3.278
39	76805	899	282.13	200	20	100	125	150	300	350	500	5000	150	5.000	2.800	286.76	101.642	7.763
40	78006	434	140.56	100	25	50	80	100	175	200	250	1000	75	5.000	2.500	104.29	74.194	3.992
41	78215	431	121.91	100	20	50	75	75	150	150	200	900	75	4.000	2.000	92.44	75.831	4.248
42	79305	456	157.77	100	20	65	90	100	200	200	250	3000	100	3.846	2.222	168.08	106.534	11.271
43	78471	812	260.78	200	25	100	100	125	300	300	400	5000	175	4.000	3.000	334.53	128.281	8.143
44	78585	876	214.92	175	25	100	100	100	250	300	400	2500	150	4.000	3.000	186.38	86.720	4.890
45	93870	826	266.97	200	15	100	120	150	300	300	500	5000	150	5.000	2.500	284.47	106.553	8.256

UNIVARIATE ON QUALITY CONTROL AND QUALITY ASSURANCE
 CRIT/UNIVO4: ADDED 20TH BOTH PERCENTILES AND RATIOS
 (USED SAS DEFINITION #2, FOR PERCENTILES)

10:52 WEDNESDAY, DECEMBER 7, 1988 3

OBS	CPT	N	MEAN	MEDIAN	MIN	P10	P20	Q1	Q3	P80	P90	MAX	ORANGE	RT9010	RT8020	STD	COEFV	SKEWNESS
1	47630	418	739.13	500	20	150	200	250	1000	1000	1500	8000	750	10.000	5.000	925.38	125.199	4.222
2	70220	925	67.35	50	4	25	40	50	100	100	100	700	50	4.000	2.500	47.08	69.912	6.467
3	70260	451	84.63	75	10	40	50	50	100	100	100	1250	50	2.500	2.000	79.76	94.243	9.092
4	70170	442	251.39	200	20	100	100	125	300	300	450	2000	175	4.500	3.000	229.70	91.369	3.784
5	70551	404	488.70	300	4	150	200	200	500	600	1000	10000	300	6.667	3.000	659.99	135.050	8.820
6	71020	926	65.82	50	5	25	33	50	100	100	100	700	50	4.000	3.030	49.25	74.835	5.662
7	71037	435	434.79	300	20	100	200	200	500	500	1000	5000	300	10.000	2.500	475.43	109.345	4.497
8	71250	441	258.96	200	20	100	100	130	300	300	500	2000	170	5.000	3.000	242.40	93.605	4.372
9	71550	795	607.93	400	50	150	200	200	600	800	1000	20000	400	6.667	4.000	1021.12	167.965	11.282
10	72110	472	75.42	75	10	30	50	50	100	100	100	400	50	3.333	2.000	39.71	52.657	2.787
11	72131	443	288.82	200	20	100	120	150	300	300	500	4000	150	5.000	2.500	329.23	117.454	5.787
12	72144	403	481.98	350	40	150	200	200	500	600	1000	5000	300	6.667	3.000	489.90	101.644	4.795
13	72266	907	357.66	250	20	100	150	150	400	500	600	10000	250	6.000	3.333	513.35	143.529	10.664
14	73110	472	56.45	50	1	20	25	25	75	90	100	1000	50	5.000	3.600	53.99	95.640	11.537
15	73140	473	44.10	40	1	10	20	20	50	60	100	150	30	10.000	3.000	28.44	64.495	0.811
16	73562	472	57.00	50	1	20	25	30	75	90	100	300	45	5.000	3.600	31.80	55.781	1.392
17	74020	926	73.72	75	0	30	50	50	100	100	100	700	50	3.333	2.000	48.50	65.789	5.748
18	74160	904	281.57	200	20	100	120	150	300	400	500	3500	150	5.000	3.333	281.26	99.889	5.350
19	74247	914	196.32	150	25	100	100	100	250	275	300	2000	150	3.000	2.750	131.64	67.057	4.721
20	74280	450	237.23	200	20	100	125	150	300	300	400	1500	150	4.000	2.400	168.37	70.972	3.376
21	74476	447	689.91	400	50	175	200	200	800	1000	1500	12000	600	8.571	5.000	1037.00	150.311	6.702
22	74741	443	204.38	150	10	100	100	100	200	300	350	2000	100	3.500	3.000	188.56	92.259	4.705
23	75631	437	585.49	400	100	175	200	225	800	1000	1000	5000	575	5.714	5.000	578.83	98.863	3.473
24	75655	454	844.24	500	10	200	275	300	1000	1000	1800	10000	700	9.000	3.636	1157.20	137.070	5.179
25	75673	890	840.19	500	50	200	250	300	1000	1000	1800	20000	700	9.000	4.000	1200.82	142.924	7.695
26	75727	436	665.05	500	75	200	220	275	1000	1000	1200	6000	725	6.000	4.545	695.89	104.638	3.707
27	75742	451	723.63	500	50	200	200	250	800	1000	1400	10000	550	7.000	5.000	1057.56	146.148	6.061
28	75754	333	678.78	500	10	150	200	250	1000	1000	1500	5000	750	10.000	5.000	698.58	102.917	2.773
29	75755	717	902.83	500	100	200	300	300	1000	1000	2000	25000	700	10.000	3.333	1346.45	149.136	9.789
30	75808	442	572.19	300	50	100	180	200	600	800	1000	10000	400	10.000	4.444	901.15	157.490	6.025
31	75821	469	214.46	200	25	100	100	100	200	250	350	3000	100	3.500	2.500	213.68	99.635	6.969
32	75963	412	933.83	500	20	200	300	300	1000	1000	1750	20000	700	8.750	3.333	1548.26	165.796	7.600
33	75983	447	814.16	500	50	200	200	250	1000	1000	1700	15000	750	8.500	5.000	1245.94	153.035	6.645
34	75990	455	542.32	300	40	100	200	200	600	800	1000	10000	400	10.000	4.000	714.61	131.769	6.683
35	76091	917	249.93	200	15	80	100	100	300	300	500	10000	200	6.250	3.000	471.90	188.814	13.955
36	76361	890	458.78	300	20	100	200	200	500	500	1000	12000	300	10.000	2.500	629.78	137.273	8.974
37	76536	434	263.59	200	20	100	125	150	300	300	500	3000	150	5.000	2.400	242.57	92.023	5.269
38	76700	460	303.65	200	50	100	150	150	300	400	500	3000	150	5.000	2.667	325.35	107.146	5.343
39	76805	894	365.38	250	25	100	150	200	400	500	800	5000	200	8.000	3.333	412.70	112.949	5.244
40	78006	425	187.59	150	20	75	100	100	200	250	300	3000	100	4.000	2.500	202.97	108.200	8.469
41	78215	426	157.34	100	10	60	100	100	200	200	300	3000	100	5.000	2.000	177.08	112.550	10.585
42	78305	455	190.02	150	20	75	100	100	200	250	300	2500	100	4.000	2.500	175.63	92.426	6.311
43	78471	815	326.32	200	40	100	150	150	350	400	500	5000	200	5.000	2.667	412.30	126.350	6.696
44	78585	868	282.81	200	20	100	100	130	300	350	500	5000	170	5.000	3.500	317.03	112.101	6.744
45	93870	833	349.47	250	15	100	150	200	400	400	600	5000	200	6.000	2.667	398.98	114.168	6.129

UNIVARIATE ON POSSIBLE HARM TO THE PATIENT
 CRIT/UNIV04; ADDED 20TH 80TH PERCENTILES AND RATIOS
 (USED SAS DEFINITION #2, FOR PERCENTILES)

10:52 WEDNESDAY, DECEMBER 7, 1988 4

OBS	CPT	N	MEAN	MEDIAN	MIN	P10	P20	Q1	Q3	P80	P90	MAX	ORANGE	RT9010	RT8020	STD	COEFV	SKEWNESS
1	47630	416	877.64	500	25	200	200	300	900	1000	1500	40000	600	7.500	5.000	2191.88	249.745	14.227
2	70220	922	34.80	20	0	1	5	10	50	50	80	800	40	80.000	10.000	56.23	161.585	8.157
3	70260	447	53.52	30	0	1	10	10	75	80	100	700	65	100.000	8.000	76.75	143.401	4.030
4	70470	442	181.77	100	0	100	100	100	200	200	300	3000	100	3.000	2.000	224.83	123.688	6.502
5	70551	406	147.80	80	0	2	10	25	200	200	400	1500	175	200.000	20.000	208.74	141.228	3.038
6	71020	921	65.95	40	0	1	10	10	100	100	100	1500	90	100.000	10.000	110.63	167.745	5.685
7	71037	438	663.03	400	1	200	200	250	700	1000	1000	12000	450	5.000	5.000	1055.03	159.122	6.807
8	71250	439	102.22	75	0	5	10	20	120	150	200	1200	100	40.000	15.000	131.36	128.514	3.841
9	71550	809	120.64	50	0	5	10	20	150	200	300	2000	130	60.000	20.000	188.83	156.530	4.333
10	72110	469	81.20	50	0	2	10	10	75	100	100	12000	65	50.000	10.000	556.91	685.868	21.050
11	72131	441	107.27	50	0	3	10	20	100	150	250	2000	80	83.333	15.000	173.98	162.188	5.568
12	72144	396	111.87	75	0	1	10	25	110	150	300	1000	85	300.000	15.000	149.75	133.862	3.103
13	72266	906	441.69	300	0	100	150	200	500	500	800	10000	300	8.000	3.333	759.18	171.881	7.456
14	73110	469	45.42	25	0	1	5	10	50	50	100	1500	40	100.000	10.000	113.50	249.905	8.664
15	73140	470	25.65	15	0	1	5	5	33	50	50	710	28	50.000	10.000	40.46	157.752	10.727
16	73562	470	69.87	25	0	1	5	10	50	55	100	10000	40	100.000	11.000	468.99	671.265	20.377
17	74020	920	42.25	25	0	5	10	10	50	60	100	800	40	20.000	6.000	56.83	134.506	6.158
18	74160	908	208.77	100	0	100	100	100	200	250	400	5000	100	4.000	2.500	334.22	160.089	10.455
19	74247	908	72.54	50	0	10	25	25	100	100	100	1000	75	10.000	4.000	85.65	118.063	6.579
20	74280	450	173.68	100	0	40	50	75	200	200	300	3500	125	7.500	4.000	256.88	147.901	7.322
21	74476	445	919.13	500	50	200	250	300	1000	1000	1500	20000	700	7.500	4.000	1771.02	192.686	6.263
22	74711	443	158.02	100	0	40	60	75	200	200	300	2500	125	7.500	3.333	197.30	124.857	6.639
23	75631	436	1068.50	500	75	200	240	300	900	1000	1250	100000	600	6.250	4.167	5170.20	483.875	16.837
24	75655	454	1803.85	1000	10	300	400	500	1200	1500	3000	100000	700	10.000	3.750	5399.78	299.347	13.910
25	75673	898	1872.46	1000	100	300	400	500	1000	1500	3000	100000	500	10.000	3.750	6372.88	340.348	12.930
26	75727	438	1148.18	500	50	200	300	300	1000	1000	1500	100000	700	7.500	3.333	5317.55	463.127	15.900
27	75742	451	1209.24	500	2	200	300	300	1000	1000	2000	100000	700	10.000	3.333	5071.85	419.423	16.997
28	75754	343	1360.09	500	0	100	200	250	1000	1000	2000	100000	750	20.000	5.000	6199.50	455.816	13.446
29	75755	724	1804.61	1000	16	300	400	500	1200	1500	2500	100000	700	8.333	3.750	6044.23	334.933	12.963
30	75808	439	365.46	200	5	100	100	100	300	400	800	10000	200	8.000	4.000	748.48	204.807	8.504
31	75821	467	209.43	150	5	100	100	100	200	250	300	5000	100	3.000	2.500	324.49	154.939	10.748
32	75963	414	1443.02	800	75	250	300	400	1200	1500	2500	100000	800	10.000	5.000	5194.05	359.943	16.905
33	75983	446	1094.41	500	0	200	300	300	1000	1000	2000	20000	700	10.000	3.333	2067.63	188.927	6.304
34	75990	454	815.63	400	0	120	200	200	800	1000	1000	70000	600	8.333	5.000	3433.20	420.928	18.331
35	76091	916	176.74	100	0	3	10	20	200	200	400	7000	180	133.333	20.000	427.54	241.911	10.154
36	76361	892	654.83	400	0	150	200	200	600	800	1000	20000	400	6.667	4.000	1332.82	203.536	9.152
37	76536	434	63.67	50	0	0	10	10	100	100	150	600	90		10.000	80.35	126.196	2.688
38	76700	460	94.43	50	0	1	10	20	100	150	200	1500	80	200.000	15.000	130.59	138.289	4.512
39	76805	897	241.16	100	0	2	10	20	250	300	500	10000	230	250.000	30.000	689.55	285.927	9.359
40	78006	426	64.10	50	0	2	10	10	100	100	100	900	90	50.000	10.000	86.57	135.064	4.302
41	78215	424	68.70	50	0	5	10	10	100	100	125	2000	90	25.000	10.000	124.40	181.088	9.917
42	78305	455	57.82	40	0	3	10	10	75	100	100	1000	65	33.333	10.000	80.13	138.582	5.691
43	78471	813	104.24	50	0	5	16	25	100	150	250	4000	75	50.000	9.375	190.53	182.786	11.753
44	78585	867	158.92	100	0	10	25	30	200	200	400	5000	170	40.000	8.000	305.79	192.412	10.033
45	93870	845	99.49	50	0	1	10	10	100	100	200	3000	90	200.000	10.000	187.90	188.867	7.276

UNIVARIATE ON OVERALL COMPLEXITY
 CRIT/UNIVO4: ADDED 20TH BOTH PERCENTILES AND RATIOS
 (USED SAS DEFINITION #2, FOR PERCENTILES)

10:52 WEDNESDAY, DECEMBER 7, 1988 5

OBS	CPT	N	MEAN	MEDIAN	MIN	P10	P20	Q1	Q3	P80	P90	MAX	ORANGE	RT9010	RT8020	STD	COEFV	SKEWNESS
1	47630	417	1150.22	750	100	300	400	500	1200	1500	2000	20000	700	6.667	3.750	1518.71	132.036	6.389
2	70220	926	52.37	50	0	20	25	30	65	75	90	710	35	4.500	3.000	41.63	79.496	7.005
3	70260	454	71.07	60	5	25	50	50	100	100	100	300	50	4.000	2.000	43.38	61.048	2.070
4	70470	445	288.60	200	20	100	150	150	300	300	450	10000	150	4.500	2.000	546.39	189.328	14.284
5	70551	408	389.87	300	50	150	200	200	500	500	700	3000	300	4.667	2.500	322.45	82.709	3.300
6	71020	927	60.49	50	0	20	30	33	75	75	100	600	42	5.000	2.500	52.02	85.986	5.345
7	71037	438	659.78	500	100	200	300	300	770	850	1000	10000	470	5.000	2.833	765.90	116.084	6.016
8	71250	444	284.46	200	50	100	135	150	300	300	500	5000	150	5.000	2.222	343.07	120.606	8.348
9	71550	803	498.08	300	50	150	200	200	500	600	900	30000	300	6.000	3.000	1168.03	234.509	20.992
10	72110	474	70.32	60	0	25	40	50	80	100	100	1000	30	4.000	2.500	64.46	91.661	8.844
11	72131	445	282.40	200	50	100	150	150	300	350	500	3000	150	5.000	2.333	268.45	95.060	5.165
12	72144	408	373.23	300	9	150	200	200	500	500	700	2500	300	4.667	2.500	288.50	77.297	3.036
13	72266	908	484.09	350	5	200	200	240	500	600	900	20000	260	4.500	3.000	797.94	164.833	17.344
14	73110	473	41.66	35	0	15	20	25	50	50	75	710	25	5.000	2.500	39.70	95.288	10.554
15	73140	474	33.41	25	0	10	15	20	50	50	50	710	30	5.000	3.333	43.42	129.971	10.809
16	73562	473	46.53	50	0	20	25	25	50	55	75	710	25	3.750	2.200	40.58	87.230	9.695
17	74020	927	61.96	50	0	25	33	40	75	80	100	500	35	4.000	2.424	40.65	65.609	3.935
18	74160	909	291.98	250	20	100	150	175	300	400	500	3000	125	5.000	2.667	227.51	77.919	4.437
19	74247	922	218.67	200	0	100	120	150	250	300	350	3000	100	3.500	2.500	169.38	77.459	7.297
20	74280	451	260.23	200	50	100	140	150	300	300	400	5000	150	4.000	2.143	291.80	112.134	10.616
21	74476	449	1055.91	610	50	250	300	400	1000	1100	2000	20000	600	8.000	3.667	1686.67	159.735	6.479
22	74741	446	234.81	200	10	100	100	120	300	300	400	3000	180	4.000	3.000	210.63	89.701	6.165
23	75631	440	897.43	550	100	250	300	400	1000	1000	1500	30000	600	6.000	3.333	1672.90	186.410	12.858
24	75655	458	1349.17	1000	150	340	500	500	1200	1500	2000	30000	700	5.882	3.000	2154.42	159.685	7.825
25	75573	895	1406.03	1000	30	350	500	600	1500	1700	2000	50000	900	5.714	3.400	2489.78	177.078	11.322
26	75727	438	979.98	700	125	300	400	400	1000	1100	2000	20000	600	6.667	2.750	1330.38	135.756	8.363
27	75742	453	1034.90	750	150	300	400	450	1000	1000	2000	20000	550	6.667	2.500	1494.10	144.372	7.174
28	75754	339	1144.32	750	30	200	300	400	1000	1200	2000	50000	600	10.000	4.000	2935.73	256.548	14.069
29	75755	715	1447.90	1000	100	350	500	600	1500	1800	2500	50000	900	7.143	3.600	2660.14	183.724	11.005
30	75808	441	869.80	500	50	200	290	300	1000	1000	1500	20000	700	7.500	3.448	1399.33	160.881	7.916
31	75821	468	240.10	200	50	100	130	150	300	300	400	1500	150	4.000	2.308	163.18	67.963	3.080
32	75963	416	1379.48	1000	125	350	500	500	1500	1600	2500	30000	1000	7.143	3.200	2027.80	146.998	8.172
33	75983	450	1359.86	800	100	300	400	500	1500	1500	2000	30000	1000	6.667	3.750	2458.49	180.791	7.163
34	75990	456	914.80	500	50	225	300	300	1000	1000	1500	20000	700	6.667	3.333	1690.04	184.743	7.924
35	76091	919	170.39	100	0	50	75	75	200	200	300	7000	125	6.000	2.667	287.77	168.886	16.088
36	76361	892	666.14	500	30	200	250	300	750	800	1000	20000	450	5.000	3.200	1090.29	163.674	10.148
37	76536	436	207.24	185	25	80	100	100	250	300	300	2000	150	3.750	3.000	170.95	82.490	4.517
38	76700	461	230.16	200	35	100	125	150	300	300	350	2000	150	3.500	2.400	171.35	74.447	4.549
39	76805	896	380.47	200	5	100	150	150	350	400	500	60000	200	5.000	2.667	2035.89	535.099	28.223
40	78006	427	131.45	100	10	50	75	75	150	200	200	1000	75	4.000	2.667	109.83	83.551	4.322
41	78215	428	121.57	100	10	50	75	75	150	150	200	1500	75	4.000	2.000	103.07	84.785	6.751
42	78305	457	138.67	100	10	50	75	80	200	200	250	900	120	5.000	2.667	94.23	67.950	2.537
43	78471	817	242.69	200	30	100	100	125	300	300	400	4000	175	4.000	3.000	245.43	101.127	7.880
44	78585	873	215.13	200	5	100	100	100	250	300	400	2000	150	4.000	3.000	168.30	78.233	3.698
45	93870	839	277.58	200	10	100	125	150	300	300	500	3000	150	5.000	2.400	266.86	96.136	5.178

UNIVARIATE ON 1 ESTIMATE IN MINUTES
 CRIT/UNIV04: ADDED 20TH BOTH PERCENTILES AND RATIOS
 (USED SAS DEFINITION #2, FOR PERCENTILES)

10.32 WEDNESDAY, DECEMBER 1968

OBS	CPT	N	MEAN	MEDIAN	MIN	P10	P20	Q1	Q3	P80	P90	MAX	ORANGE	RT9010	RT8020	STD	COEFV	SKEWNESS
1	47630	386	188.13	100	12	50	60	60	150	180	200	2500	90	4.000	3.000	353.211	187.751	4.645
2	70220	910	8.23	5	0	2	2	3	10	10	15	100	7	7.500	5.000	11.103	134.857	3.685
3	70260	443	10.56	5	1	3	4	5	10	10	20	100	5	6.667	2.500	13.693	129.647	3.858
4	70470	431	33.06	20	1	7	10	10	30	30	50	800	20	7.143	3.000	64.706	195.722	6.970
5	70551	382	49.41	20	2	10	12	15	40	45	90	1000	25	9.000	3.750	100.785	203.973	5.360
6	71020	909	8.32	5	0	2	2	3	8	10	15	100	5	7.500	5.000	13.074	157.183	4.351
7	71037	420	98.90	60	15	30	40	45	75	90	120	1500	30	4.000	2.250	177.256	179.219	4.883
8	71250	429	34.50	20	3	10	10	15	30	30	60	600	15	6.000	3.000	65.714	190.495	5.740
9	71550	749	51.55	30	2	10	15	15	45	60	90	1000	30	9.000	4.000	104.502	191.576	5.396
10	72110	467	10.87	5	1	2	3	4	10	13	20	100	6	10.000	4.333	15.388	141.518	3.728
11	72131	424	34.60	20	2	10	10	12	30	30	50	600	18	5.000	3.000	70.265	203.056	5.932
12	72144	379	50.33	20	2	10	15	15	40	45	90	1000	25	9.000	3.000	100.925	200.517	5.518
13	72266	885	81.27	45	1	30	30	30	60	60	90	6000	30	3.000	2.000	232.179	285.681	19.488
14	73110	465	6.88	5	0	1	2	2	7	10	15	80	5	15.000	5.000	9.130	132.626	4.227
15	73140	467	5.70	3	0	1	2	2	5	5	10	85	3	10.000	2.500	8.522	149.615	5.127
16	73562	465	7.39	5	0	1	2	3	10	10	15	85	7	15.000	5.000	10.247	138.640	4.114
17	74020	905	9.80	5	1	2	3	4	10	10	15	200	6	7.500	3.333	14.338	146.368	5.563
18	74160	885	38.21	20	1	10	10	15	30	35	60	750	15	6.000	3.500	71.920	188.240	5.420
19	74247	908	38.18	20	3	12	15	15	30	30	45	1500	15	3.750	2.000	82.342	215.664	9.759
20	74280	442	41.55	25	3	15	15	20	35	40	50	1500	15	3.333	2.667	98.502	221.129	9.495
21	74476	431	151.26	80	5	45	60	60	120	120	180	10000	60	4.000	2.000	528.390	349.326	15.680
22	74741	433	51.96	30	2	15	20	20	45	45	60	1200	25	4.000	2.250	107.257	206.419	7.134
23	75631	415	137.96	90	20	45	60	60	120	120	180	2000	60	4.000	2.000	241.580	175.113	5.351
24	75655	435	191.94	100	5	50	60	60	150	150	200	10000	90	4.000	2.500	567.682	295.763	12.927
25	75673	858	186.98	120	2	60	70	90	150	180	200	5000	60	3.333	2.571	371.156	198.504	6.758
26	75727	416	158.13	90	10	60	60	60	120	150	180	2000	60	3.000	2.500	272.976	172.625	4.916
27	75742	426	154.99	75	4	45	50	60	120	120	150	10000	60	3.333	2.400	546.208	352.409	14.521
28	75751	292	125.97	75	5	20	30	35	120	120	180	5000	85	9.000	4.000	335.266	266.149	11.358
29	75755	618	175.60	90	0	60	60	60	120	150	180	4000	60	3.000	2.500	377.515	214.991	6.843
30	75808	419	175.25	120	2	45	60	60	160	180	240	6000	100	5.333	3.000	380.012	216.839	10.581
31	75821	458	52.43	30	2	15	20	20	45	45	60	3000	25	4.000	2.250	152.818	291.445	16.128
32	75963	382	208.25	120	3	60	75	90	150	180	240	5000	60	4.000	2.400	435.860	209.300	6.397
33	75983	431	187.66	120	5	60	60	75	150	180	240	10000	75	4.000	3.000	540.190	287.850	14.685
34	75990	437	146.92	60	4	40	45	60	100	120	180	10000	40	4.500	2.667	536.501	365.166	15.160
35	76091	900	18.32	10	1	4	5	5	15	20	30	500	10	7.500	4.000	98.186	208.464	7.848
36	76361	858	88.51	60	1	30	30	40	60	80	120	2000	20	4.000	2.667	159.468	180.163	6.238
37	76536	421	35.74	20	0	10	10	12	30	30	45	1000	18	4.500	3.000	83.709	234.241	7.351
38	76700	449	33.76	15	1	5	10	10	30	30	45	500	20	9.000	3.000	67.692	200.487	4.940
39	76805	871	38.84	20	1	8	10	12	30	30	45	1000	18	5.625	3.000	89.935	231.570	6.652
40	78006	412	18.72	10	1	4	5	5	20	20	30	250	15	7.500	4.000	30.796	164.544	4.657
41	78215	413	14.20	10	1	3	4	5	15	15	30	150	10	10.000	3.750	19.861	139.902	3.419
42	78305	447	20.85	10	1	4	5	5	15	20	40	400	10	10.000	4.000	41.642	199.700	5.620
43	78471	761	30.88	15	1	5	10	10	30	30	60	500	20	12.000	3.000	50.287	162.852	4.670
44	78585	839	26.35	10	1	5	5	5	20	30	50	500	15	10.000	6.000	51.084	193.836	5.329
45	93870	785	44.19	20	1	10	10	15	30	45	60	2500	15	6.000	4.500	120.736	273.189	12.921

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
 FIVE-YEAR REVIEW PROCESS
 SUMMARY OF RECOMMENDATION

CPT Code: 70336 Global Period: XXX Current RVW: .95 Recommended RVW: 1.48

CPT Descriptor: Magnetic resonance (eg, proton) imaging, temporomandibular joint

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Thirty year old female with pain and clicking in the region of the TMJ on chewing.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 507 Response Rate (%): N = 165 (32.5%) Median RVW: 1.48

25th Percentile RVW: 1.30 75th Percentile RVW: 1.50 Lowest RVW: 0.45 Highest RVW: 2.00

Median Total Service Time: 20 minutes 25th Percentile Total Service Time: 15 minutes

75th Percentile Total Service Time: 25 minutes Lowest Total Time: 4 minutes

Highest Total Time: 60 minutes

Median Complexity Source (1 = least complex, 5 = most complex):

Factor	70336	72148	70551	73220	Average of all References
Mental Effort and Judgement	4.0	4.0	4.0	4.0	4.0
Technical Skill and Physical Effort	3.0	3.0	4.0	3.0	3.3
Psychological Stress	3.0	3.0	3.0	2.5	2.83

Median Total Time (Minutes):

70336	72148	70551	73220	Average of all References
20	20	22.5	20	20.83

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	1.48
2) 73720	Magnetic resonance (eg, proton) imaging, lower extremity, other than joint	1.48
3) 73220	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint	1.48

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 70336 is nearly identical to its key reference services (codes 72148, 73720, and 73220) with respect to total procedure time. Furthermore, code 70336 and its references have comparable intensity scores.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The ACR's recommended RVW for code 70336 is the survey's median value (1.48). The results of the survey confirm the belief that code 70336 is comparable to other non-contrast MRI procedures in terms of both time and intensity. It, therefore, should have the same RVW.

The survey respondents were split over whether or not the work has changed over the last five years (51.9 percent of the respondents thought the work has changed, 48.1 percent did not). [For a discussion of how the work has changed, see the following paragraph.] The majority of the respondents (63.8 percent) did not believe that technology lessened the amount of work involved in the procedure. On the other hand, 41.3 percent of the respondents thought that their patients have become more complex (54.1 percent indicated no change). The procedure's site of service has not changed (95.4 percent). Lastly, nearly all of the respondents (92.0 percent) agreed with the vignette.

Although the survey results were unclear with respect to changes in physician work, since the time the procedure was originally valued, new pulse sequences have been developed which are of value in studying the temporomandibular joint. These new pulse sequence add to the number of images that must be interpreted, thus increasing physician time. Code 70336 was undervalued originally and, therefore, should be brought up to the level of comparable examinations.

ATTACHMENT
SERVICE DESCRIPTION

Code Being Rated: 70336

Magnetic resonance (eg, proton) imaging, temporomandibular joint

Pre-Service:

1. Discuss examination with patient and review history.
2. Instruct technologist as to appropriate pulse sequences.

Intra-Service:

1. Review images from various pulse sequences.
2. Determine if additional pulse sequences or studies are necessary.

Post-Service:

1. Dictate report to referring physician.
2. Communicate findings to referring physician.

CMD Comments

06-Jul-95

Code: 70336

1995 RVUs: 0.95

Recommended RVUs: 1.48

Ratio: 0.56

Long Descriptor: Magnetic resonance (eg, proton) imaging, temporomandibular joint

Reference Set (y/n): N Global Period: XXX Frequency: 1,633 Impact: 865.49

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACR

Societies Wishing to Comment: ACEP, AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
70336	15	0	2.6	85	22.5	0	0	5.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
70336	1651	1808	4.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
70336	4.5	6.5	1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
70336	group practices	2.3
	radiology	94.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
70336	350	1.3	TRIGEMINAL NERVE DISORDERS
	435	1.3	TRANSIENT CEREBRAL ISCHEMIA
	524	11.3	DENTOFACIAL ANOMALIES, INCLUDING MALOCCLUSION
	526	2.5	DISEASES OF THE JAWS

CMD Comments

06-Jul-95

784	1.3	SYMPTOMS INVOLVING HEAD AND NECK
830	3.1	DISLOCATION OF JAW
977	1.3	POISONING BY OTHER AND UNSPECIFIED DRUGS AND MEDICINAL SUBSTANCES
V72	6.3	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
70336							
ACR	26		XXX	.	0.95	.	0.95
CMD	26		XXX	.	0.95	.	0.95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
70336								
ACR	0.95	0.95	.	1.00	1.00	1.00	1.48	299
CMD	0.95	0.95	.	1.00	1.00	1.00	1.48	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
70336								
ACR	XXX	.	.	.	.	.	.	.
CMD	XXX	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
70336									
ACR
CMD

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
70336									
ACR	.	.		1.48	0.95				
CMD	.	.		1.48	0.95				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 73221 Global Period: XXX Current RVW: .95 Recommended RVW: 1.48

CPT Descriptor: Magnetic resonance (eg, proton) imaging, any joint of upper extremity

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Fifty-seven year old male with increasing inability to elevate his arm above his head and shoulder pain.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 507 Response Rate (%): N = 180 (35.5%) Median RVW: 1.48

25th Percentile RVW: 1.48 75th Percentile RVW: 1.54 Lowest RVW: 0.80 Highest RVW: 2.80

Median Total Service Time: 20 minutes 25th Percentile Total Service Time: 15 minutes

75th Percentile Total Service Time: 30 minutes Lowest Total Time: 5 minutes

Highest Total Time: 63 minutes

Median Complexity Source (1 = least complex, 5 = most complex):

Factor	73221	72148	73220	73720	Average of all References
Mental Effort and Judgement	4.0	4.0	4.0	4.0	4.0
Technical Skill and Physical Effort	4.0	3.0	3.0	3.0	3.0
Psychological Stress	3.0	3.0	2.0	3.0	2.83

Median Total Time (Minutes):

73221	72148	73220	73720	Average of all References
20	20	25	20	21.67

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	1.48
2)	73220	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint	1.48
3)	73720	Magnetic resonance (eg, proton) imaging lower extremity, other than joint	1.48
4)	73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity	0.95

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 73221 is nearly identical to its key reference services (codes 72148, 73720, and 73220) with respect to total procedure time. Furthermore, code 73221 and its references have comparable intensity scores.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The ACR's recommended RVW for code 73221 is the survey's median value (1.48). The results of the survey confirm the belief that code 73221 is comparable to other non-contrast MRI procedures in terms of both time and intensity. It, therefore, should have the same RVW.

The majority of the respondents (69.5 percent) believe that the work involved in the procedure has changed over the last five years (30.5 percent did not). [For a discussion on how the work has changed, see next paragraph.] Furthermore, the majority of the respondents (77.4 percent) did not believe that technology lessened the amount of work involved in the procedure. Almost half (47.8 percent) of the respondents thought that their patients have become more complex (50.7 percent indicated no change). The procedure's site of service has not changed (93.4 percent). Lastly, nearly all of the respondents (92.2 percent) agreed with the vignette.

Over the past few years, new pulse sequences of value for the shoulder and other upper extremity joints have been developed. As a consequence, the procedure now takes longer to perform since it results in more images for the radiologist to interpret. Code 73221 was undervalued originally and should be brought up to the level of comparable examinations.

ATTACHMENT
SERVICE DESCRIPTION

Code Being Rated: 73221

Magnetic resonance (eg, proton) imaging, any joint of upper extremity

Pre-Service:

1. Discuss examination with patient and review history.
2. Instruct technologist as to appropriate pulse sequences.

Intra-Service:

1. Review images from various pulse sequences.
2. Determine if additional pulse sequences or studies are necessary.

Post-Service:

1. Dictate report to referring physician.
2. Communicate findings to referring physician.

CMD Comments

06-Jul-95

Code: 73221

1995 RVUs: 1.48

Recommended RVUs: 1.48

Ratio: 0.00

Long Descriptor: Magnetic resonance (eg, proton) imaging, any joint of upper extremity

Reference Set (y/n): N Global Period: XXX Frequency: 40,586 Impact: 0

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACR

Societies Wishing to Comment: ACEP, AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
73221	30.4	3.8	8.4	54	11.5	0.2	0.5	8.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
73221	29432	43824	22

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
73221	3.2	2.9	-0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
73221	group practices	2.6
	radiology	92.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
73221	715	1.2	OSTEOARTHRISIS AND ALLIED DISORDERS
	719	9.4	OTHER AND UNSPECIFIED DISORDERS OF JOINT
	726	3.9	PERIPHERAL ENTHESOPATHIES AND ALLIED SYNDROMES

CMD Comments

06-Jul-95

840	8	SPRAINS AND STRAINS OF SHOULDER AND UPPER ARM
V72	6.7	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
73221							
ACR	26		XXX	.	0.95	.	0.95
CMD	26		XXX	.	0.95	.	0.95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
73221								
ACR	0.95	0.95	.	1.00	1.00	1.00	1.48	299
CMD	0.95	0.95	.	1.00	1.00	1.00	1.48	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Htime	Notett	Imppt
73221								
ACR	XXX	.	.	.	.	.	.	.
CMD	XXX	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
73221									
ACR
CMD

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
73221									
ACR	.	.		1.48	0.95				
CMD	.	.		1.48	0.95				

CMD Comments

06-Jul-95

V72	7.4	SPECIAL INVESTIGATIONS AND EXAMINATIONS
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
73720							
CMD	26		XXX		1.48		1.48

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
73720								
CMD	1.48	1.48		1.00	1.00	1.00	1.48	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
73720								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
73720									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
73720									
CMD				1.48	1.48				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 73721 Global Period: XXX Current RVW: .95 Recommended RVW: 1.48

CPT Descriptor: Magnetic resonance (eg, proton) imaging, any joint of lower extremity

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Forty-six year old male with increasing pain on motion of the knee joint and occasional locking of joint.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 507 Response Rate (%): N = 179 (35.3%) Median RVW: 1.48

25th Percentile RVW: 1.48 75th Percentile RVW: 1.54 Lowest RVW: 0.80 Highest RVW: 2.70

Median Total Service Time: 20 minutes 25th Percentile Total Service Time: 15 minutes

75th Percentile Total Service Time: 30 minutes Lowest Total Time: 4 minutes

Highest Total Time: 90 minutes

Median Complexity Source (1 = least complex, 5 = most complex):

Factor	73721	70551	72141	72148	73720	Average of all References
Mental Effort and Judgement	4.0	4.0	4.0	4.0	4.0	4.0
Technical Skill and Physical Effort	3.0	3.5	2.0	3.0	3.0	2.87
Psychological Stress	3.0	3.0	3.0	3.0	3.0	3.0

Median Total Time (Minutes):

73721	70551	72141	72148	73720	Average of all References
20	16.5	15	20	25	19.12

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	1.48
2) 72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	1.60
3) 72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	1.48
4) 73220	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint	1.48

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 73721 is nearly identical to its key reference services (codes 70551, 72141, 72148, 73720) with respect to total procedure time. Furthermore, code 73221 and its references have comparable intensity scores.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The ACR's recommended RVW for code 73721 is the survey's median value (1.48). The results of the survey confirm the belief that code 73721 is comparable to other non-contrast MRI procedures in terms of both time and intensity. It, therefore, should have the same RVW.

The majority of the respondents (72.2 percent) believe that the work involved in the procedure has changed over the last five years (27.8 percent did not). [For a discussion on how the work has changed, see next paragraph.] Furthermore, the majority of the respondents (77.7 percent) did not believe that technology lessened the amount of work involved in the procedure. Slightly over half (51.4 percent) of the respondents thought that their patients have become more complex (47.9 percent indicated no change). The procedure's site of service has not changed (92.1 percent). Lastly, the vast majority of the respondents (88.9 percent) agreed with the vignette.

Since the time the procedure was originally valued, new pulse sequences of value have been developed for the knee, hip, and other joints. These new pulse sequences add to the time it takes to perform the procedure and the time necessary to interpret the resulting images.

ATTACHMENT
SERVICE DESCRIPTION

Code Being Rated: 73721

Magnetic resonance (eg, proton) imaging, any joint of lower extremity

Pre-Service:

1. Discuss examination with patient and review history.
2. Instruct technologist as to appropriate pulse sequences.

Intra-Service:

1. Review images from various pulse sequences.
2. Determine if additional pulse sequences or studies are necessary.

Post-Service:

1. Dictate report to referring physician.
2. Communicate findings to referring physician.

CMD Comments

06-Jul-95

Code: 73721

1995 RVUs: 0.95

Recommended RVUs: 1.48

Ratio: 0.56

Long Descriptor: Magnetic resonance (eg, proton) imaging, any joint of lower extremity

Reference Set (y/n): N

Global Period: XXX

Frequency: 81,739

Impact: 43321.67

Source: 2

Year: 92

Public Comment Letter:

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACR

Societies Wishing to Comment: ACEP, AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
73721	30.5	5	9.4	68.7	13.1	0.6	1.3	7.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
73721	65625	85330	14

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
73721	5.3	5.6	0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
73721	group practices	2.5
	radiology	92.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
73721	715	1.3	OSTEOARTHRITIS AND ALLIED DISORDERS
	717	3.1	INTERNAL DERANGEMENT OF KNEE
	719	9.7	OTHER AND UNSPECIFIED DISORDERS OF JOINT
	836	6.8	DISLOCATION OF KNEE

CMD Comments

06-Jul-95

V72	7.5	SPECIAL INVESTIGATIONS AND EXAMINATIONS
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Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
73721							
ACR	26		XXX	.	0.95	.	0.95
CMD	26		XXX	.	0.95	.	0.95

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
73721								
ACR	0.95	0.95	.	1.00	1.00	1.00	1.48	299
CMD	0.95	0.95	.	1.00	1.00	1.00	1.48	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	hime	Notett	Imppt
73721								
ACR	XXX	.		.		.		.
CMD	XXX	.		.		.		.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
73721									
ACR
CMD

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
73721									
ACR	.	.		1.48	0.95				
CMD	.	.		1.48	0.95				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
 FIVE-YEAR REVIEW PROCESS
 SUMMARY OF RECOMMENDATION

CPT Code: 74330 Global Period: XXX Current RVW: .79 Recommended RVW: 0.90

CPT Descriptor: Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Forty eight year old female with acute pancreatitis and elevated liver function enzymes. Suspect common duct stone. Rule out pancreatic mass.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 511 Response Rate (%): N = 182 (35.6%) Median RVW: 0.90

25th Percentile RVW: 0.75 75th Percentile RVW: 1.20 Lowest RVW: 0.3 Highest RVW: 3.0

Median Total Service Time: 30 minutes 25th Percentile Total Service Time: 15 minutes

75th Percentile Total Service Time: 45 minutes Lowest Total Time: 2 minutes

Highest Total Time: 130 minutes

Median Complexity Source (1 = least complex, 5 = most complex):

Factor	74330	74329	74240	75820	75980	Average of all References
Mental Effort and Judgement	3.0	3.0	3.0	3.0	4.0	3.25
Technical Skill and Physical Effort	2.0	2.0	3.0	2.0	3.5	2.62
Psychological Stress	2.0	2.0	2.0	2.0	3.0	2.25

Median Total Time (Minutes):

74330	74329	74240	75820	75980	Average of all References
30	20	15	13.5	52.5	25.25

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	0.70
2) 74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	0.69
3) 75820	Venography, extremity, unilateral, radiological supervision and interpretation	0.70
4) 75980	Perctaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation	1.44

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

In many regards, code 74330 is comparable to its key reference procedures (74329, 74240, 75820, and 75980). First of all, code 74330 is clinically similar to code 74329, with the exception that both the biliary and pancreatic ducts are studied (rather than just the pancreatic ducts). Next, it shares with its reference procedures many of the same intensity scores. With respect to time and RVW, code 74330 approaches code 75980 (RVW = 1.44), than the other reference codes (RVW 0.69 to 0.70).

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The ACR's recommended RVW for code 74330 is the survey's median value (0.90). The results of the survey confirm the belief that code 74330 should be rated higher than code 74329, since both biliary and pancreatic ducts are studied.

The majority of the respondents (61.2 percent) felt that the work involved in the procedure has not changed over the last five years (38.8 percent did). In addition, the majority of the respondents (83.8 percent) disagreed with the premise that technology lessened the amount of work involved in the procedure. Most radiologists (61.9 percent) felt that their patients are now more complex (38.1 percent indicated no change). The procedure's site of service has not changed much, only 15.1 percent indicated a change (mostly from inpatient to outpatient). Lastly, the vast majority of the respondents (87.2 percent) agreed with the vignette.

The proposed RVW for code 74330 corrects the mistake made when it was assigned the same RVW as code 74329. The time commitment for radiologists during catheterization of both the pancreatic duct and common bile duct by the endoscopist is clearly more than that for a single duct. Although the physician work associated with the interpretation of images for a single duct system has not changed, work associated with interpreting images to evaluate both systems is clearly greater.

In addition, therapeutic interventional biliary procedures (e.g. sphincterotomy, stone extraction, stent placement) have been developed in the past five years, significantly increasing the time associated with this procedure.

ATTACHMENT
SERVICE DESCRIPTION

Code Being Rated: 74330

Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation

Pre-Service:

Review case history, previous films, and clinical record.

Intra-Service:

Fluoroscope, supervise procedure, advise endoscopist and interpret images.

Post-Service:

Review films with endoscopist, dictate report.

Public Comments

06-Jul-95

Code: 74330 1995 RVUs: 0.7 Recommended RVUs: 1.05 Ratio:

Long Descriptor: Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation

Reference Set (y/n): N Global Period: XXX Frequency: 59,319 Impact: 20762

Source: 2 Year: 92 Public Comment Letter: 299

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACR

Societies Wishing to Comment: AOA

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
74330	49.1	14.9	12.4	61.5	7.5	0.5	1.7	9.4

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
74330	58659	64108	4.5

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
74330	64.4	63.2	-0.6

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
74330	gastroenterology	2.1
	group practices	3.4
	radiology	92

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
74330	574	4.5	CHOLELITHIASIS
	575	1	OTHER DISORDERS OF GALLBLADDER
	576	4	OTHER DISORDERS OF BILIARY TRACT

Public Comments

06-Jul-95

577	2.9	DISEASES OF PANCREAS
786	1.9	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS
789	7.9	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
V72	9.3	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
74330							
ACR	26		XXX		0.70		0.70

Harvard Data:

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
74330								
ACR	0.70	0.70		1.00	1.00	1.00	1.05	299

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
74330								
ACR	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
74330									
ACR									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twrput	lwput
74330									
ACR				1.05	0.70				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 75630 Global Period: XXX Current RVW: 1.31 Recommended RVW: 2.45

CPT Descriptor: Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation.

Source and Summary of Comment to HCFA on this service: SCVIR. Raise value to equal the combined work of 75625 and 75716.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Specialty: _____

Sample Size: _____ Response Rate (%): _____ Median RVW: _____

25th Percentile RVW: _____ 75th Percentile RVW: _____ Low: _____ High: _____

Median Pre-Service Time: _____ Median Intra-Service Time: _____

25th Percentile Intra-Svc Time: _____ 75th Percentile Intra-Svc Time: _____ Low: _____ High: _____

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure:

ICU:

Other Hospital:

Office:

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	75625	Aortography, abdominal, radiological supervision and interpretation	1.14
2)	75716	Angiography, extremity, bilateral radiological supervision and interpretation	1.31
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

See Rationale

RATIONALE

This code describes the radiological supervision and interpretation of aortography and bilateral lower extremity arteriograms. The radiologic supervision and interpretation service described by this code involves evaluation of the aorta and lower extremity arteries to the distal circulation. We note that the supervision and interpretation of an abdominal aortogram (75625) and supervision and interpretation for bilateral extremity arteriography (75716) are valued at 1.14 RVW and 1.31 RVW respectively. Since CPT 75630 involves the work of both 75625 and 75716, we believe that the work of 75630 can be readily derived by adding the work values of 75625 and 75716 for a total of 2.45.

Public Comments

06-Jul-95

Code: 75630

1995 RVUs: 1.31

Recommended RVUs: 2.45

Ratio:

Long Descriptor: Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation

Reference Set (y/n): N Global Period: XXX Frequency: 74,516 Impact: 84948

Source: 2 Year: 92 Public Comment Letter: 317

Reference Services:

CMD Comment:

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Societies Wishing to Survey: SCVIR

Societies Wishing to Comment: ACR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
75630	43.9	8.3	13.5	46.3	7.1	0.8	4.2	11.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
75630	100592	84870	-8.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
75630	60.9	57.7	-1.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
75630	cardiovascular disease	7.3
	group practices	3.3
	interventional radiolog	5.1
	radiology	80.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
75630	440	4.1	ATHEROSCLEROSIS
	441	1.8	AORTIC ANEURYSM

Public Comments

06-Jul-95

443	4.9	OTHER PERIPHERAL VASCULAR DISEASE
444	5.4	ARTERIAL EMBOLISM AND THROMBOSIS
447	2.6	OTHER DISORDERS OF ARTERIES AND ARTERIOLES
729	1.1	OTHER DISORDERS OF SOFT TISSUES
786	1.4	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS
V72	9.1	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
75630							
SCVIR	26		XXX		1.31		1.31

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
75630								
SCVIR	1.31	1.31		1.00	1.00	1.00	2.45	317

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
75630								
SCVIR	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
75630									
SCVIR									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
75630									
SCVIR				2.45	1.31				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
 FIVE-YEAR REVIEW PROCESS
 SUMMARY OF RECOMMENDATION

CPT Code: 76090 Global Period: XXX Current RVW: .25 Recommended RVW: 0.58

CPT Descriptor: Mammography, unilateral

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

55 year old female recently had a screening mammogram. An asymmetrical density was identified in the left breast and further mammographic evaluation was recommended.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 496 Response Rate (%): N = 184 (37.1%) Median RVW: 0.58

25th Percentile RVW: 0.43 75th Percentile RVW: 0.75 Lowest RVW: 0.22 Highest RVW: 1.90

Median Total Service Time: 15 minutes 25th Percentile Total Service Time: 8 minutes

75th Percentile Total Service Time: 20 minutes Lowest Total Time: 3 minutes

Highest Total Time: 45 minutes

Median Complexity Source (1 = least complex, 5 = most complex):

Factor	76090	74240	71020	76645	Average of all References
Mental Effort and Judgement	4.0	3.0	3.0	3.0	3.0
Technical Skill and Physical Effort	3.0	3.0	3.0	3.0	3.0
Psychological Stress	4.0	2.0	2.0	3.0	2.33

Median Total Time (Minutes):

76090	74240	71020	76645	Average of all References
15	15	5	10	10.0

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	0.69
2) 71020	Radiologic examination, chest, two views, frontal and lateral	0.22
3) 76645	Echography, breast(s) (unilateral or bilateral), B-scan and/or real time with image documentation	0.54

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Mammography is one of the most demanding studies to interpret and the results reflect this. With respect to intensity, code 76090 surpasses many of its reference codes (74240, 71020, and 76645) individually and collectively. Furthermore, its total time estimate places it in the vicinity of code 74240, with an RVW of 0.69.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The ACR's recommended RVW for code 76090 is the survey's median value (0.58).

The majority of the respondents (61.9 percent) felt that the work involved in the procedure has changed over the last five years (38.1 percent did not). [For a discussion of how the work has changed, see the following paragraphs.] In addition, the vast majority of the respondents (95.4 percent) disagreed with the premise that technology lessened the amount of work involved in the procedure. Most radiologists (62.2 percent) felt that their patients are now more complex (37.8 percent indicated no change). Nearly ninety percent (89.4 percent) of the respondents indicated that the procedure's site of service has not changed. Lastly, the vast majority of the respondents (91.8 percent) agreed with the vignette.

Mammography has experienced fundamental changes since originally valued in 1988. In 1988 and 1989, landmark articles (attached) established that supplemental views are frequently needed to evaluate potentially significant abnormalities identified on the basic views. These additional diagnostic views have become a standard part of mammographic examinations (see enclosed tables from "Quality Determinants of Mammography" Physician Insurers Association of America, "Practical Solutions to Common Mammographic Problems: Tailoring the Examination", Breast Masses: Mammographic Evaluation") and add physician work. Prior to publication of the articles (and the seminars that followed) mammography basically consisted of two standard views (CC and MLO) of each breast. This was the norm at the time mammography was valued during the radiology RVS. The vignette used in 1988 to set the relative values for 76091 ("for bilateral breast pain") would more appropriately apply to code 76092 (screening mammography) today.

Radiologists face increased communication requirements. In 1988, it was not standard for the radiologist to interact with the patient (e.g. history taking, physical examination if indicated, discussion of results, and recommendations). This is expected today. Also, it is no longer sufficient to simply supply a formal dictated report to the referring physician. Reports in lay-person terms are sometimes prepared and sent to the patient. If the report is abnormal it must be communicated by phone to the referring physician or to the patient if she has no referring physician (Quality Determinants of Mammography, US Department of Health and Human Services, AHCPR, October, 1994, page 42. Also requirements of Mammography Quality Standards Act, and some state regulations).

In addition to the added number of views and the extra time required to interpret them, the malpractice risk (psychological stress) has substantially increased. According to the June 1995 Physician Insurers Association of America (PIAA) breast cancer study (attached), malignant neoplasm of the female breast are the most frequently filed medical insurance claims. Furthermore, radiologists were the most frequent defendants having been named in 24% of the cases (1995), up from 11.4% in 1990. In addition, the awards per case have risen 36% since 1990.

ATTACHMENT
SERVICE DESCRIPTION

Code Being Rated: 76090

Mammography, unilateral

Pre-Service:

1. Review pertinent mammograms.
2. Discuss examination with patient and obtain clinical history.
3. Examine breast for any palpable abnormality in the area of concern, and mark skin with B-B if appropriate.
4. Instruct technologist as to appropriate views.

Intra-Service:

1. View additional films and compare with previous films.
2. Determine if additional views or studies (e.g., ultrasound) are indicated.
3. Interpret significance of findings on the films, and correlate with the physical findings.
4. Discuss findings and recommendations with the patient. Inform patient when to expect the final results and recommendations from her referring physician.

Post-Service:

1. Dictate report to referring physician.
2. If an abnormal exam requiring biopsy, communicate results by phone to referring physician.
3. Prepare written notification of results and further steps to be taken, in lay language, to be sent to the patient.

Public Comments

06-Jul-95

Code: 76090

1995 RVUs: 0.25

Recommended RVUs: 0.65

Ratio:

Long Descriptor: Mammography, unilateral

Reference Set (y/n): N

Global Period: XXX

Frequency: 502,067

Impact: 200827

Source: 2

Year: 92

Public Comment Letter: 299

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACR

Societies Wishing to Comment: AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
76090	42.2	6.3	6.8	99.5	4	0.1	0.2	12

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
76090	456486	521946	6.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
76090	1.9	1.4	-0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
76090	group practices	4.4
	internal medicine	2
	radiology	88.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
76090	174	4	MALIGNANT NEOPLASM OF FEMALE BREAST
	610	3.8	BENIGN MAMMARY DYSPLASIAS
	611	9.9	OTHER DISORDERS OF BREAST

Public Comments

06-Jul-95

793	1.2	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF BODY STRUCTURE
V10	4.1	PERSONAL HISTORY OF MALIGNANT NEOPLASM
V72	8.5	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
76090							
ACR	26		XXX		0.25		0.25

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
76090								
ACR	0.25	0.25		1.00	1.00	1.00	0.65	299

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
76090								
ACR	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
76090									
ACR									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
76090									
ACR				0.65	0.25				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 76091 Global Period: XXX Current RVW: .41 Recommended RVW: 0.69

CPT Descriptor: Mammography; bilateral

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

49 year old female patient with a history of a palpable mass in the right breast. Previous mammograms, the last performed two years earlier, are available for review and comparison.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 496 Response Rate (%): N = 179 (36.1%) Median RVW: 0.69

25th Percentile RVW: 0.50 75th Percentile RVW: 0.85 Lowest RV W: 0.35 Highest RVW: 2.2

Median Total Service Time: 15 minutes 25th Percentile Total Service Time: 10 minutes

75th Percentile Total Service Time: 20 minutes Lowest Total Time: 3 minutes

Highest Total Time: 90 minutes

Median Complexity Source (1 = least complex, 5 = most complex)

Factor	76091	71020	74240	74400	Average of all References
Mental Effort and Judgement	4.0	3.0	3.0	3.0	3.0
Technical Skill and Physical Effort	3.0	2.0	3.0	2.0	2.33
Psychological Stress	4.0	2.0	2.0	3.0	2.33

Median Total Time (Minutes):

76091	71020	74240	74400	Average of all References
15	5	15	10	10

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 71020	Radiologic examination, chest, two views, frontal and lateral	0.22
2) 74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	0.69
3) 74400	Urography (pyelography), intravenous, with or without KUB, with or without tomography	0.49

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Mammography is one of the most demanding studies to interpret and the results reflect this. With respect to intensity, code 76091 surpasses many of its reference codes (74240, 71020, and 74400) individually and collectively. Furthermore, its total time estimate places it on par with code 74240, which has an RVW of 0.69.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The ACR's recommended RVW for code 76091 is the survey's median value (0.69).

The majority of the respondents (59.8 percent) felt that the work involved in the procedure has changed over the last five years (38.1 percent did not). [See the following paragraphs for a discussion of how the work involved in the procedure has changed.] In addition, the vast majority of the respondents (94.3 percent) disagreed with the premise that technology lessened the amount of work involved in the procedure. As with code 76090, most radiologists (62.2 percent) felt that their patients are now more complex (37.8 percent indicated no change). Nearly ninety percent (87.3 percent) of the respondents indicated that the procedure's site of service has not changed (12.2 percent suggested a change to an outpatient setting). Lastly, the vast majority of the respondents (93.7 percent) agreed with the vignette.

Mammography has experienced fundamental changes since originally valued in 1988. In 1988 and 1989, landmark articles (attached) established that supplemental views are frequently needed to evaluate potentially significant abnormalities identified on the basic views. These additional diagnostic views have become a standard part of mammographic examinations (see enclosed tables from "Quality Determinants of Mammography" Physician Insurers Association of America, "Practical Solutions to Common Mammographic Problems: Tailoring the Examination", Breast Masses: Mammographic Evaluation") and add physician work. Prior to publication of the articles (and the seminars that followed) mammography basically consisted of two standard views (CC and MLO) of each breast. This was the norm at the time mammography was valued during the radiology RVS. The vignette used in 1988 to set the relative values for 76091 ("for bilateral breast pain") would more appropriately apply to code 76092 (screening mammography) today.

Radiologists face increased communication requirements. In 1988, it was not standard for the radiologist to interact with the patient (e.g. history taking, physical examination if indicated, discussion of results, and recommendations). This is expected today. Also, it is no longer sufficient to simply supply a formal dictated report to the referring physician. Reports in lay-person terms are sometimes prepared and sent to the patient. If the report is abnormal it must be communicated by phone to the referring physician or to the patient if she has no referring physician (Quality Determinants of Mammography, US Department of Health and Human Services, AHCPR, October, 1994, page 42. Also requirements of Mammography Quality Standards Act, and some state regulations).

In addition to the added number of views and the extra time required to interpret them, the malpractice risk (psychological stress) has substantially increased. According to the June 1995 Physician Insurers Association of America (PIAA) breast cancer study (attached), malignant neoplasm of the female breast are the most frequently filed medical insurance claims. Furthermore, radiologists were the most frequent defendants having been named in 24% of the cases (1995), up from 11.4% in 1990. In addition, the awards per case have risen 36% since 1990.

Public Comments

06-Jul-95

Code: 76091

1995 RVUs: 0.41

Recommended RVUs: 0.80

Ratio:

Long Descriptor: Mammography; bilateral

Reference Set (y/n): Y Global Period: XXX Frequency: 2,330,791 Impact: 909008

Source: 2 Year: 92 Public Comment Letter: 299

Reference Services:

CMD Comment:

--

Societies Wishing to Survey: ACR

Societies Wishing to Comment: AOA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
76091	34.7	4.5	9.5	99.4	6.2	0.1	0.2	11.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
76091	2838821	2421060	-7.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
76091	1.9	1.5	-0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
76091	group practices	4.6
	internal medicine	2.5
	radiology	87.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
76091	610	9.9	BENIGN MAMMARY DYSPLASIAS
	611	11.5	OTHER DISORDERS OF BREAST
	V72	7.8	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Public Comments

06-Jul-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
76091							
ACR	26	XXX	XXX	0.52	0.41	0.79	0.41

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
76091								
ACR	0.41	0.41	0.79	1.00	1.00	1.00	0.80	299

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
76091								
ACR	XXX	0.52	t	.		8	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
76091									
ACR									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
76091									
ACR				0.80	0.41	ra	n	0.065	

ATTACHMENT
SERVICE DESCRIPTION

Code Being Rated: 76091

Mammography; bilateral

Pre-Service:

1. Review previous mammograms.
2. Discuss examination with patient and obtain clinical history.
3. Examine area of concern in breast(s).
4. Mark area of clinical concern (if applicable) with lead B-B marker on skin.
5. Instruct technologist as to appropriate views.

Intra-Service:

1. Review films and compare with previous examinations (e.g., determine if area of clinical concern is included on the films and that mammographic abnormality, if any, corresponds to the area of clinical concern).
2. Interpret significance of findings on the films and correlate with the physical findings.
3. Determine if additional views or additional studies (e.g., breast ultrasound) are indicated.
4. Discuss findings and recommendations with the patient. Inform patient when to expect the final results and recommendations from her referring physician.

Post-Service:

1. Dictate report to referring physician.
2. If an abnormal exam, requiring biopsy, communicate results by phone to referring physician.
3. Prepare written notification of results and further steps to be taken, in lay language, to be sent to the patient.

Clinical Practice Guideline

Clinical Practice Guideline

Number 13

Quality Determinants of Mammography



Quality Mammography

U.S. Department of Health and Human Services
Public Health Service
Agency for Health Care Policy and Research

Quality Determinants of Mammography

Table 1. Diagnostic views for mammography

Projection/view (abbreviation)	Indications	How it provides higher quality images and how the information improves interpretation and patient management
Spot compression (Can be done in any of the projections below)	To confirm an abnormality is real. To better define a lesion obscured by overlying tissue.	Separates tissues overlying and obscuring an area of interest; provides increase in local compression (bringing object closer to film). Eliminates the need for biopsy if lesion is shown to be factitious. Can confirm need for biopsy.
Magnification (M) (Can be done in any of the projections below)	To better define calcifications and margins of masses.	Improved definition of abnormality will help determine whether it is suspicious and requires biopsy or whether it is probably benign and can be followed.
90° lateral (ML, LM)	To localize an abnormality (in conjunction with CC). To confirm presence of a lesion seen on only one standard view. To demonstrate gravity- dependent material (milk- of-calcium).	Provides view directly at right angles to CC, allowing 3-dimensional localization so that mammographic finding can be correlated with clinical breast examination and, if nonpalpable, can be removed by needle localization, resulting in minimal biopsy scar. As a third view, can confirm whether lesion is real or factitious. If calcifications are shown to be gravity dependent, they represent benign "milk-of-calcium" and a biopsy can be avoided.

See note at end of table.

Activities During the Examination

Table 1. Diagnostic views for mammography (continued)

Projection/view (abbreviation)	Indications	How It provides higher quality images and how the information improves interpretation and patient management
Exaggerated craniocaudal (XCCL)	To localize an abnormality seen on MLO but not CC and expected to be in the posterolateral part of the breast or axillary tail. May be needed to image the lateral-most portion of the breast in some women with prominent axillary tissue.	Images posterolateral breast tissue, which is not always demonstrated with standard CC positioning. Allows localization of lesions in outer breast for correlative examination and, if suspicious, for needle localization.
Cleavage (CV)	To localize an abnormality seen on MLO but not CC and expected to be in the deep medial breast.	Images posteromedial breast tissue, which may not be seen with standard CC positioning, allowing for correlative examination or needle localization.
Axillary tail (AT)	To localize an abnormality high in the tail of Spence and not seen on standard views.	Images axillary tail of breast tissue.
Tangential (TAN)	To depict a palpable lesion that is obscured by overlying dense tissue. To verify the dermal location of calcifications or skin lesions.	By placing a palpable lesion that is obscured by overlying tissue directly over radiolucent subcutaneous fat, the lesion may be seen so that it can be characterized as benign or suspicious. By directing the beam tangential to skin calcifications, a suspected dermal location can be confirmed and unnecessary biopsy avoided.

See note at end of table.

Quality Determinants of Mammography

Table 1. Diagnostic views for mammography (continued)

Projection/view (abbreviation)	Indications	How it provides higher quality images and how the information improves interpretation and patient management
Roll (RL, RM)	To bring a lesion that is obscured by overlying tissue into view. To estimate the location of a lesion seen in only one view by observing how it moves on roll views.	By rolling the breast, the relationship between a lesion and overlying tissues will be changed and the lesion may be better visualized. The direction the lesion moves may help in determining its location. It may be useful in better defining or localizing a lesion seen on only one view.
Caudocranial (FB) (from below)	To better define the nature of a mass in the upper part of the breast or include more of it on the image. To improve positioning of some patients with problematic body habitus. May also be used for preoperative needle localizations of lesions near the inferior skin surface.	Because an abnormality high in the breast will be closer to the film on the FB, it can be better defined. Because the compression plate will be moving against movable rather than fixed tissue, more of the deep superior tissues can be included on the image.
Lateromedial oblique (LMO)	To improve positioning of some patients with problematic body habitus (kyphosis) and pacemakers. To better depict lesions in the superomedial part of the breast.	By reversing the location of compression device and Bucky, more tissue can be included and better compression achieved in some patients. Lesions in the superomedial aspect of the breast will be closer to the film.
Superolateral to inferomedial oblique (SIO)	For needle localization of lesions seen in AT view but not CC.	Can be done at 90° to AT view, allowing needle localization and wire placement for abnormalities that are seen on AT view but not on CC or XCCL views.

See note at end of table.

Table 1. Diagnostic views for mammography (continued)

Projection/view (abbreviation)	Indications	How it provides higher quality images and how the information improves interpretation and patient management
Implant displacement (ID)	To better image patients with augmentation mammoplasties.	By displacing the implant posteriorly and pulling tissue anteriorly away from the implant, more compression can be applied to improve visualization of tissues.
Imaging mastectomy site	To identify recurrent breast cancer at chest wall.	It is controversial whether this is an effective procedure. Most recurrences at the chest wall are clinically detected. When performed, a mediolateral oblique projection of the mastectomy site or an axillary view is done.
Conservatively treated breast: preradiotherapy magnification views over site of segmental resection	To identify residual tumor at the surgical site, particularly calcifications of nonpalpable intraductal cancer.	Identifying residual tumor and removing it before radiotherapy may decrease incidence of recurrent breast cancer at the surgical site.
Conservatively treated breast: postradiotherapy magnification views over site of segmental resection	Performed at regular intervals to identify recurrent cancer.	By placing a wire directly over the surgical site and using magnification films at regular intervals, it may be possible to identify changes of recurrent cancer as early as possible.
Specimen radiography	To verify that a nonpalpable lesion is present in a biopsy specimen from a mammographically guided localization procedure. Locates abnormality for the pathologist's attention on the area of concern (the area requiring detailed histological evaluation).	Verification of the presence of the lesion on the specimen radiograph ensures that the suspicious finding has been removed for pathologic evaluation. If the lesion is not present in the first specimen radiograph, additional tissue will be excised and radiographed.

Note: CC = craniocaudal. MLO = mediolateral oblique.

July 1988

31

Practical Solutions to Common Mammographic Problems: Tailoring the Examination

Edward A. Sickles¹

It is quite common for standard two-view-per-breast mammography to produce inconclusive results, especially among symptomatic patients and in interpreting baseline screening examinations. Many of these cases are read as indeterminate simply because the imaging evaluation is incomplete. In such circumstances, additional views prove invaluable in solving the mammographic problems raised on the standard examination. The ability to decide which extra views to obtain, and when to use them, is an important part of the expertise that every mammographer should develop.

In discussing the problem-solving approach to mammography, I have assumed the use of dedicated mammographic equipment, capable of imaging in the cranio-caudal projection with a vertical X-ray beam, in the lateral projection with a horizontal X-ray beam, and in all intermediate degrees of the oblique projection. I also have assumed that a properly designed breast compression device is used [1]. These features are essential for screen-film mammography and preferable for xeroradiography as well [1]. Use of a ceiling-mounted X-ray unit produces acceptable xeroradiographic images in standard projections, but the radiologist using this general-purpose equipment is limited in the ability to take full advantage of many special projections devised to solve mammographic problems. Every busy xeroradiographic breast imaging practice should have at least one dedicated mammographic unit available for such problem-solving examinations.

There are so many potential approaches to completing the evaluation of inconclusive mammography examinations that an almost innumerable array of imaging permutations exists from which the radiologist may choose. To simplify the subject, I have concentrated on some of the more commonly encountered mammographic problems, indicating those solutions most likely to succeed. The reader is advised at the outset that every mammographic problem can be solved by a variety of acceptable methods and that my failure to discuss one of your personal favorites indicates only my own preference rather than the inadequacy of a specific alternative approach.

Lesion Seen on Only One Standard Projection

The most common mammographic problem, and the one most frequently left unsolved by inexperienced radiologists, is that of the lesion identified on only one standard projection. This usually involves a mass or asymmetric density, but can also occur with a cluster of tiny calcifications. The major decision to make in this situation is whether an abnormality indeed exists, or whether the "lesion" represents a fortuitous superimposition of otherwise innocuous overlapping shadows. Especially with considerable experience, this decision often can be made simply by analyzing the standard views, trying to convince oneself that a superimposition is present (Fig. 1). However, even in the most skilled hands this is not always possible. Furthermore, some radiologists are reluctant to engage in over-attempting such an

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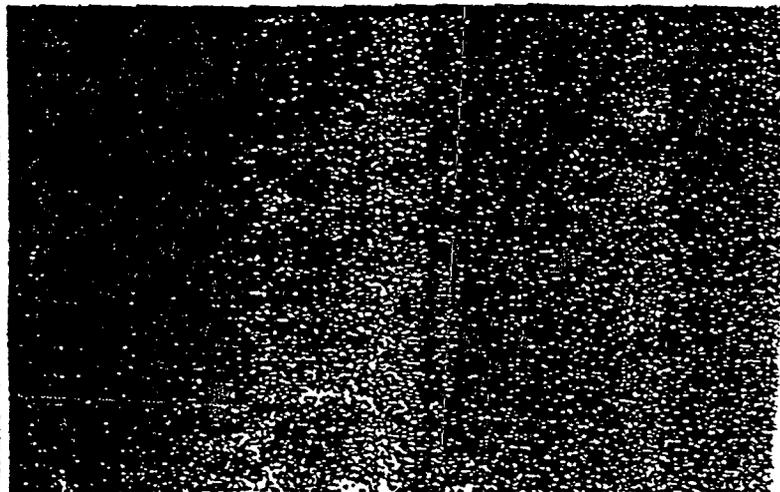
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Fig. 1.—Recognizing the presence of superimposition on two standard views only.
A, Mediolateral oblique view shows dense mass of irregular contour.
B, Craniocaudal view shows several vague opacities of somewhat lower density, each at a distance from the nipple consistent with the location of the mass seen on oblique view. Many experienced radiologists will recognize the combination of findings as representing superimposition of benign retropectoral structures with a sufficient degree of confidence that a confirmatory additional view is not necessary.

assessment. In any circumstance, one must resist the temptation to bypass the abnormality-vs-superimposition decision by interpreting all such findings as being suspicious for malignancy. This only puts off the problem until the almost inevitable preoperative needle localization, at which time it usually is too late to decide in favor of superimposition because the patient and surgeon have been irreversibly primed for biopsy. The result when superimposition truly is present is either unnecessary surgery, or correct identification of the error at the expense of lost confidence by the patient and surgeon in the reliability of mammography as a whole and in the skill of the offending radiologist in particular.

The proper approach to determining the importance of a finding seen on only one standard projection is to obtain an additional view or views that resolve the situation. The initial step in this process is an assessment of whether the lesion is located too deep in the breast to have been included on the second standard view. A rough approximation that may be useful is comparison of the distance between the lesion and the nipple on the first view and the distance between the nipple and back of the film on the second view [2]. If there is any doubt that the lesion may not have been included on the second view, then its location on the first view will govern which of many additional projections should be obtained next. Most of the available extra views are described later in this article.

Once the radiologist is convinced that the finding could not have been cut off the view on which it is not seen, the next step is to establish or exclude the possibility of superimposi-

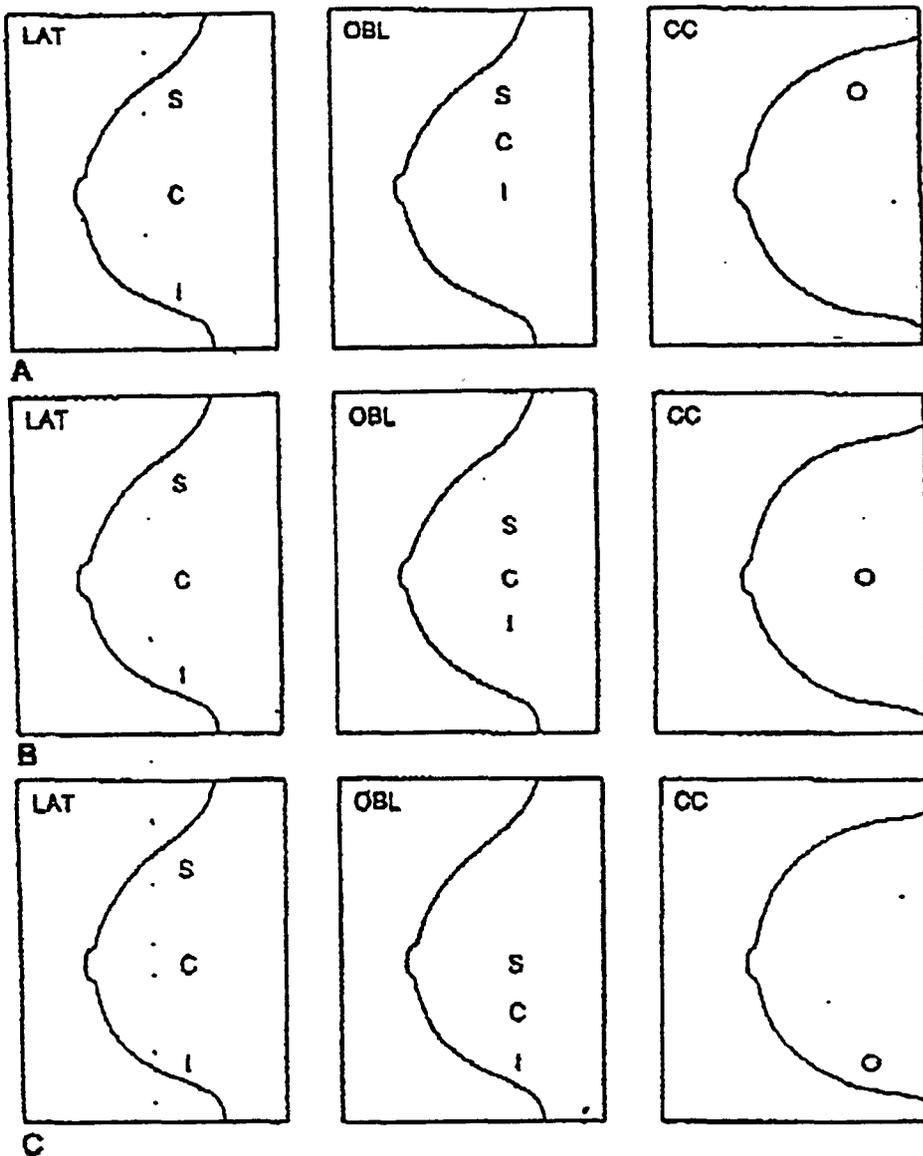
tion. This is best done by taking an additional view in projection only slightly different from the one in which the lesion was first seen. The rationale behind this approach is that a real abnormality will be seen readily when the obliquity of the X-ray beam changes slightly, whereas superimposed normal structures will present a very different, much less worrisome radiographic appearance. Several methods have been proposed to achieve this result, including simply repeating the initial standard view with the expectation that a minor variation in projection is bound to occur [3, 4]; intentional changing the obliquity of the X-ray beam [4], usually by 10-15° from the initial standard view [5]; or changing orientation of the breast itself by "rolling" it slightly with respect to the positioning device (Fig. 2). These techniques almost always are effective in projecting the breast tissue in a somewhat different manner, except that the experienced technologist may be so successful in reproducing standard views that for her the latter methods will work best.

Two other techniques also are helpful in differentiating between a true abnormality and superimposed normal structures. One is to use increased breast compression, or, because this spreads apart overlying islands of dense tissue permitting more accurate diagnosis [5]. Most effective in regard is the use of a spot compression device or at least use of a device that is so small that it compresses only the area of interest, not the entire breast. In addition, any compression translates readily into superior magnification because geometric unsharpness is lessened and magnification is increased. Also, if tighter beam collimation

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CUSTOMIZED MAMMOGRAPHY

Fig. 4.—Standard lateral (LAT), oblique (OBL), and craniocaudal (CC) projections of breast show expected locations of lesions on lateral view if they were seen initially only on craniocaudal and oblique views. Lesion is lateral (L), central (C), and medial (M) parts of breast on craniocaudal views. Note three possible locations of this lesion on oblique view (S = superior, C = Central, I = inferior), and then find corresponding locations on lateral view.



lesions often are not included at all on the mediolateral oblique view and may not be imaged completely on either standard craniocaudal or lateral views. An exaggerated medial craniocaudal view usually will include the entire abnormality, as may a lateromedial lateral view (see following). However, for the deepest of these lesions, the best available view is an oblique projection with the X-ray beam passing from superolateral to inferomedial location, the so-called "reverse oblique" projection [5].

Lesions located very high up on the chest wall.—These usually are readily imaged on either the standard lateral or oblique view, but often are the most difficult abnormalities to include on the craniocaudal view because the vigorous compression needed to display breast structures with proper detail usually does not permit the uppermost portions of the

breast to be imaged (Fig. 6). Several approaches can help resolve this problem. The best method is to simply include under the compression device only the uppermost breast tissues, producing a so-called "lumpogram" (Fig. 7). If the lesion is palpable, a small metal marker should be used to provide proper correlation of its location with that of the mammographic abnormality (Fig. 8). Otherwise, the lateral, central, or medial location of the lesion on the craniocaudal projection should be deduced by triangulation from lateral and oblique views, as described before. This will permit the appropriate portion of the upper breast to be included in the lumpogram. Another method to produce vertical-beam images of very superiorly located lesions is to support the bottom of the breast with a wedge-shaped sponge, permitting more effective breast positioning so that deeper tissues are

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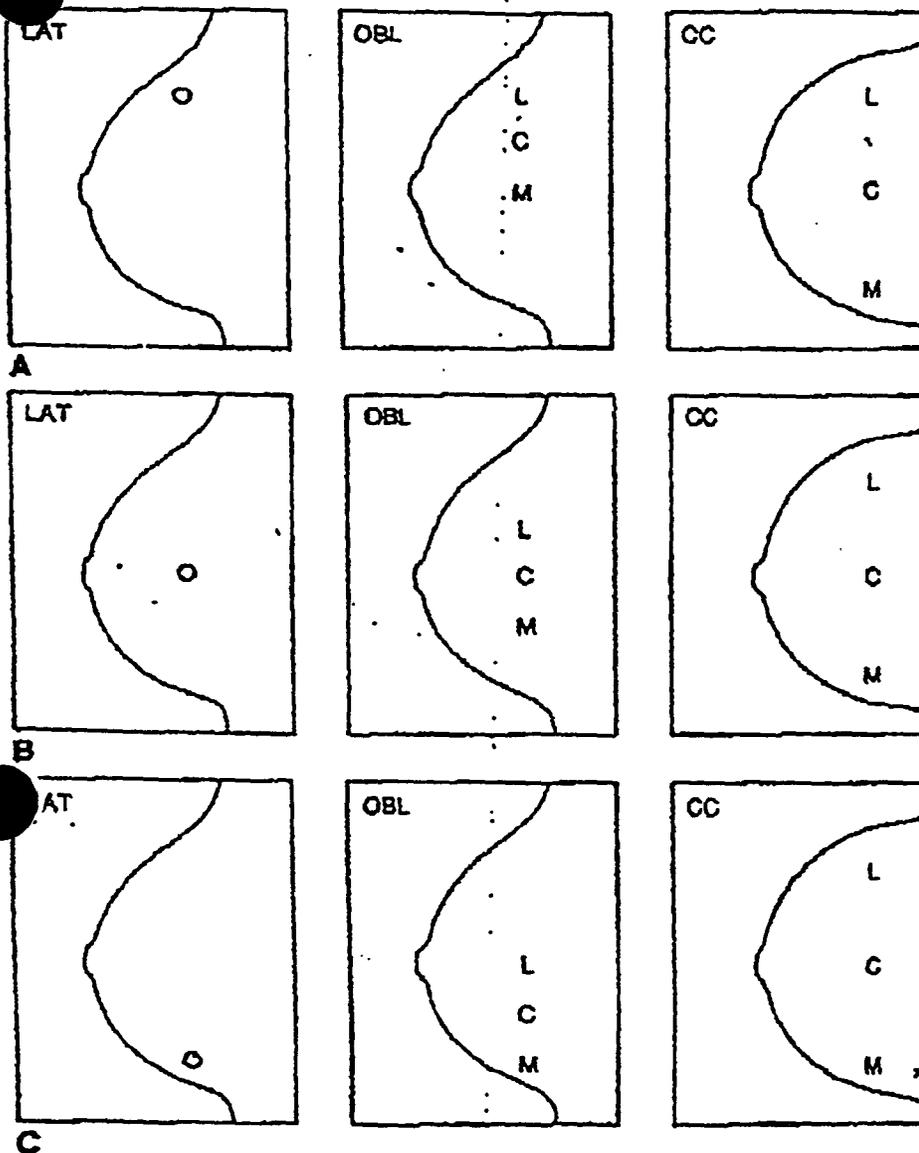


Fig. 5.—Standard lateral (LAT), oblique (OBL), and craniocaudal (CC) projections of breast show expected locations of lesions on craniocaudal view if they were seen initially only on lateral and oblique views. Lesion is in superior (A), central (B), and inferior (C) parts of breast on lateral view. Mark three possible locations of this lesion on oblique view (L = lateral, C = central, M = medial), and then find corresponding locations on craniocaudal view.

included on the craniocaudal projection [12]. Unfortunately, the use of such a sponge precludes vigorous breast compression, severely limiting the value of this method. Two other techniques, available with only a few dedicated mammography units, involve either imaging in the caudocranial projection or varying the obliquity of the craniocaudal beam slightly off true vertical in a posteroanterior direction. These techniques also allow deeper breast structures to be included in the radiographic field.

Lesions located so close to the chest wall that nothing else works.—It must be exceedingly rare for a palpable lesion to defy inclusion on any of the previously discussed mammographic views; in over 100,000 cases, I have never needed to resort to further inventive maneuvers. However, sooner or later every busy radiologist will encounter that most difficult

of lesions for which truly heroic efforts are required. The most interesting suggestion I have seen for this problem is to use coned-down compression along with an independent restraining device that pulls the lesion away from the chest wall ~~when~~ the exposure is taken. A metal coat hanger appears to be an ideal restraining device because it is malleable enough to mold into whatever shape is necessary, strong enough to hold the lesion in place, and thin enough not to interfere with breast compression [5].

Further Characterize an Already Detected Abnormality

Just as there are numerous special mammographic projections available to more effectively include a lesion in a

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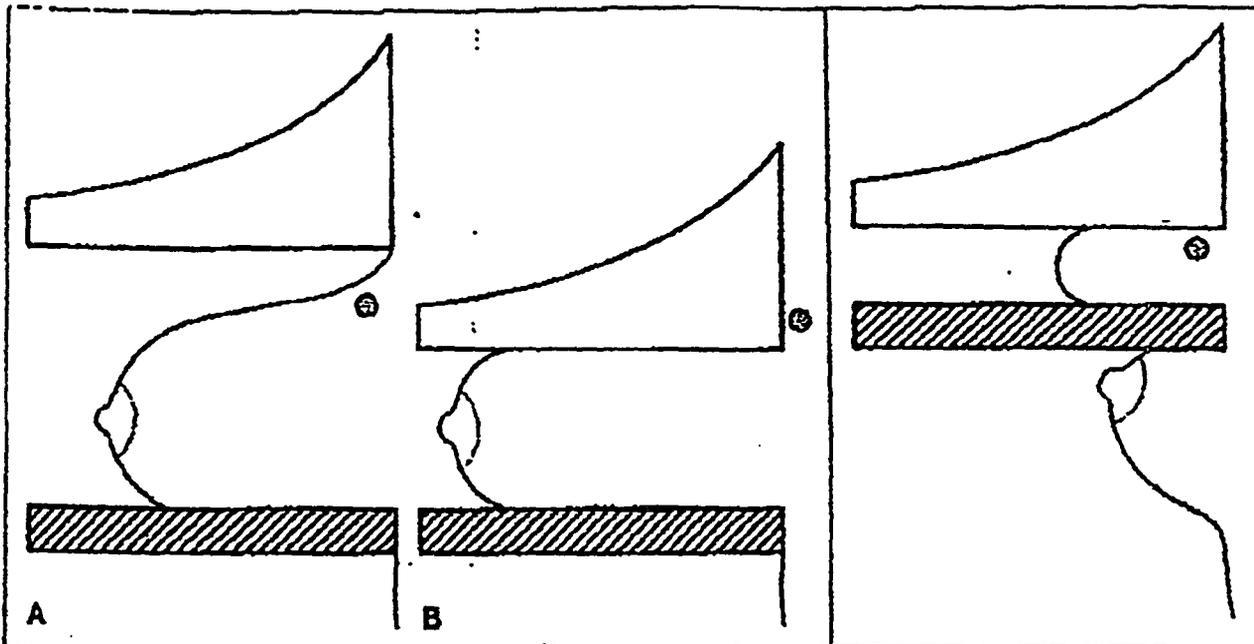


Fig. 6.—How proper breast compression prevents inclusion on standard craniocaudal view of lesion very high up on chest wall.

A. Lesion located far superiorly in breast, before compression is applied for imaging in craniocaudal projection.

B. While vigorous compression is applied (which would be done to optimize image quality and flatten out breast to uniform thickness), compression plate has traveled so far down chest wall that lesion is not included in craniocaudal image.

Fig. 7.—Same lesion as in Fig. 6, with imaging of only the uppermost breast tissues ("tempogram"). This permits lesion to be included in craniocaudal projection image while vigorous compression is applied.

mographic view, so are there a wide variety of techniques to better characterize abnormalities that are imaged with less than optimal clarity. Several among these are so obvious that they do not deserve special discussion, including the correction of under- or overexposure or under- or overpenetration, elimination of inadvertent patient motion, and repeat imaging after removal of confounding artifacts.

Lateromedial vs mediolateral lateral views.—Because most breast cancers occur in the outer half of the breast, the standard image in the lateral projection is obtained with a mediolateral X-ray beam, because this places the outer aspect of the breast closer to the cassette to minimize geometric unsharpness. However, when an abnormality is detected in the inner breast, it is preferable to take any repeat lateral projection exposures with a lateromedial beam [2]. This will produce sharper images of the lesion.

Full range of oblique views.—The standard mediolateral oblique projection is obtained with the plane of breast compression parallel to that of the pectoralis major muscle. This usually results in an X-ray beam obliquity of 45–60° off horizontal. On the other hand, dedicated mammography units are capable of imaging in any plane of obliquity, including reverse oblique projections. When a lesion is partly obscured by overlying dense fibroglandular structures on one or both standard views, it may be helpful to take an additional exposure with a nonconventional degree of beam obliquity. The

rationale behind this approach is to project the lesion so that it overlies an area of fatty tissue, where its border characteristics can be analyzed more readily. Often more than one attempt is needed to achieve proper results, especially in women with dense breasts.

Tangential view.—One possible purpose for obtaining a tangential view of a breast abnormality is to establish or exclude dermal location for a lesion. Skin lesions are important to recognize because invariably they are benign, never representing primary breast carcinoma. Most common among such lesions are clustered dermal calcifications, which can be confused with those of malignancy when they are very small, when they project over the breast parenchyma on both standard views, and when they do not show characteristically benign radiolucent centers [14–16]. Experienced technologists often can obtain a tangential view of such calcifications, or of any lesion suspected of being located in the skin, simply by estimating the degree of needed change in X-ray beam or breast obliquity. There is also a foolproof method that requires one extra exposure before the tangential view is taken [17]. A tiny metal marker is placed on the breast so that it is seen to precisely overlie the lesion on an additional craniocaudal view (the marker is placed on the top of the breast if the lesion projects superiorly on the lateral view; otherwise it is positioned on the underside of the breast). If the lesion indeed is dermal in location the marker will again superimpose on

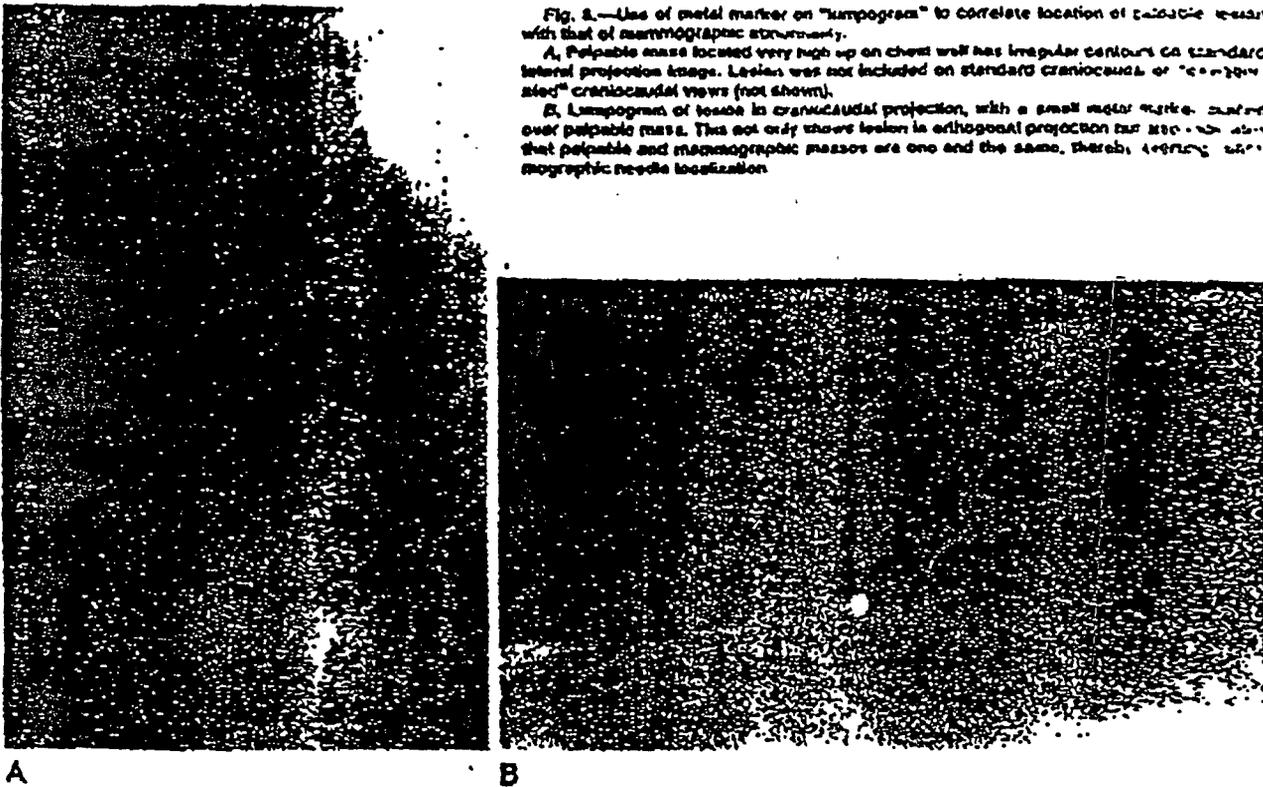


Fig. 2.—Use of metal marker on "Lumpogram" to correlate location of calcific lesion with that of mammographic abnormality.

A. Palpable mass located very high up on chest wall has irregular contours on standard lateral projection image. Lesion was not included on standard craniocaudal or "conventional" craniocaudal views (not shown).

B. Lumpogram of same in craniocaudal projection, with a small metal marker placed over palpable mass. This not only shows lesion in orthogonal projection but also shows that palpable and mammographic masses are one and the same, thereby, allowing mammographic needle localization.

the lesion when any other projection is obtained, although a tangential view of the marker produces the most convincing results.

A second purpose for obtaining a tangential view involves parenchymal abnormalities: to project the lesion as close as possible to the subcutaneous fat, where its margins may be seen with greater clarity. This approach is especially useful when standard-projection mammograms show only dense fibroglandular tissue despite the presence of a palpable mass or focal area of skin dimpling [5]. Many radiologists will routinely obtain an extra tangential view of any palpable lesion that is not readily seen on conventional mammograms.

Coned-down compression view.—The many imaging advantages to vigorous breast compression include reduced patient motion, decreased geometric unsharpness, increased contrast, and the spreading apart of superimposed islands of fibroglandular tissue [1]. A spot-compression device is especially effective in producing these improvements in image quality, because its compressive force is applied to a relatively small area of interest, rather than being spread out over the entire breast as would be necessary to provide conventional uniform-thickness compression. If tighter beam collimation is used along with spot compression, this even further increases radiographic contrast. As a result, many radiologists will obtain an additional coned-down spot-compression view of any lesion not seen with optimum clarity on standard-projection mammograms.

Magnification views.—The technique of direct radiographic

magnification also is widely acknowledged to produce superior-quality mammographic images. This has been verified both in the laboratory and in clinical trials [6, 18-20]. However, to be successful, magnification technique requires the use of an X-ray tube with a tiny focal spot. For example, the required (not nominal) focal spot size should be less than 0.3 mm for 1.5X magnification [21]; even smaller focal spots are required for the higher degrees of magnification provided by some current mammographic units. The radiologist, having proper equipment should consider obtaining extra magnification views whenever a lesion is seen with less than optimal clarity on conventional mammograms. In this clinical setting, magnification mammography has been shown to correctly guide management decisions in many cases, either toward prompt biopsy if malignancy is present or toward further diagnostic examinations for benign lesions [5, 6, 19, 22]. Magnification and spot compression techniques can be used simultaneously. Furthermore, these two techniques can be combined either singly or together, with any of the other techniques described previously.

Conclusions

This article describes a systematic approach to solving some of the more commonly encountered mammographic problems. In tailoring such examinations to the specific needs of individual patients, the neophyte mammographer should proceed in a step-by-step manner, using the techniques

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CUSTOMIZED MAMMOGRAPHY

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at a time. This is advisable primarily because it will be much easier to learn the strengths and limitations of each imaging maneuver separately, as it actually works on your own patients, with your own equipment, in the hands of your own technologists. However, once sufficient experience is gained, it will be advantageous to devise successful combinations of these extra views, with the aim of using as few exposures as possible. Why try to limit the number of films taken? One important reason is that the imaging advantages of several maneuvers often are additive, producing a single picture of even better image quality than would occur if the same maneuvers were undertaken separately. Other reasons, of lesser significance, are that radiation dose is lowered and that examination time and interpretation time are shortened, thereby reducing operating costs. Finally, it is worthwhile to minimize the number of extra exposures because repeated requests for "just one more film" may cause the patient to lose confidence in the specific personnel involved and perhaps in the practice of mammography as well.

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The reader's attention is directed to the Commentary on this article, which appears on the following pages.

State of the Art

Edward A. Sickles, MD

Breast Masses: Mammographic Evaluation¹

MAMMOGRAPHY frequently demonstrates masses within the breast in both symptomatic and asymptomatic women. Occasionally, these masses have characteristically benign radiographic features, causing little difficulty in diagnosis. Even less commonly, masses may demonstrate typically malignant mammographic features that are just as easy to recognize as their clearly benign counterparts. However, most masses exhibit at least some image properties intermediate between benign and malignant, thereby prompting indeterminate mammographic interpretations and leading to further, often invasive diagnostic procedures. Some radiologists are considerably more successful than others in differentiating benign from malignant masses.

The purpose of this article is to provide a systematic and practical approach to the imaging evaluation of noncalcified breast masses. The reader is encouraged to interpret each mass in the step-by-step manner indicated in the text that follows. Establish the presence of a mass and then evaluate its size, location, density, shape, clarity of margins, and interval change.

To a great extent this problem-solving process requires additional images to supplement the standard craniocaudal and side views taken of

each breast. Dedicated mammography equipment, especially when used with vigorous breast compression, substantially enhances the radiologist's ability to make more definitive interpretations (1,2), as do the capability to produce fine-detail spot compression magnification mammograms and the interpretive skill to utilize the additional radiographic information provided by these high-resolution images (3,4).

SYSTEMATIC ANALYSIS OF BREAST MASSES**Differentiation of True Masses from Masslike Findings**

The first step in any evaluation of breast masses is to define exactly what does and does not constitute a mass, to distinguish true masses both from (benign) asymmetric areas of increased density and from summation shadows produced by fortuitous superimposition of normal fibrous and glandular structures. Masses have an outwardly convex contour, are at least as dense centrally as at the periphery, and are demonstrated on at least two different mammographic projections, preferably orthogonal views. In contradistinction, asymmetric densities characteristically have scalloped concave contours and are interspersed with fatty elements (5,6), while summation shadows cannot be visualized on more than one projection, even with only minor degrees of variation in x-ray beam obliquity (2,7).

Size

The size of a breast mass as measured with mammography is not particularly helpful in predicting either benign or malignant origin, because benign masses substantially outnumber cancers for lesions of all sizes. However, there is a clear trend to-

ward detection of smaller and smaller breast cancers. In the 1970s fewer than 10% of cancers detected at the University of California San Francisco (UCSF) Medical Center were smaller than 1 cm, but since 1985 the median size of screening-detected malignancies has decreased to 1.2 cm and fewer than 20% of our cancers are 2 cm or larger.

The size of a mass does have considerable impact on its subsequent management. For a large mass, especially one greater than 2-3 cm, aspiration or biopsy probably will be done independent of mammographic features, simply because of the increased likelihood that it will be palpable and that the findings of physical examination themselves will prompt a further invasive diagnostic procedure. Similarly, for a small mass, ultrasound (US) examination may not be undertaken even if it otherwise would be indicated, principally because very small nonpalpable lesions often are missed using handheld US units. The smallest size amenable to sonographic study varies from 0.5 cm to 1 cm, depending on the US equipment, the skill of the examiner, the location of the mass (deeper lesions are harder to identify), and the amount of time one is willing to allot for sonographic detection of a mass. There also is a lower limit in size below which most radiologists totally discount the importance of a mass with benign-appearing mammographic characteristics. This limit usually ranges from 0.5 cm to 1 cm, based primarily on one's own personal definition of what constitutes "benign-appearing" features. In establishing such a definition, each radiologist must weigh the opportunity to detect well-circumscribed cancers when they are very small against the morbidity and expense involved in further evaluating lesions for which the likelihood of malignancy is extremely low.

Index terms: Breast diseases, 00.48, 00.71, 00.72, 00.74 • Breast neoplasms, diagnosis, 00.31, 00.32 • Breast radiography, 00.11 • State-of-Art reviews

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Biopsy Results as a Function of Quadrant Location for Mammographically Visible Noncalcified Masses

Location	Benign	Preadmalignant	Malignant
Upper outer	132 (56)	14 (48)	91 (52)
Upper inner	40 (14)	6 (21)	26 (15)
Lower outer	28 (10)	3 (10)	19 (11)
Lower inner	21 (7)	1 (3)	14 (8)
Retroaxillar	41 (15)	5 (17)	25 (14)

Source.—Data from all UCSF mammography examinations, both symptomatic and asymptomatic women, 1985–1998.

Note.—Numbers in parentheses are percentages.
 1 Lesion location determined by retrospective review of mammograms. Lesion situated equally between quadrants allocated half and half to each quadrant. Retroaxillar location—more than half of lesion within axillary margin.
 2 Preadmalignant: lobular carcinoma in situ, atypical hyperplasia with cellular atypia.
 3 Malignant: ductal carcinoma in situ, all types of carcinoma.

Location

Just as is observed for lesion size, the location of a breast mass usually is not helpful in differentiating benignity from malignancy. Radiologists generally are familiar with the frequency distribution of breast cancers by quadrant location, most common in the upper outer quadrant and least common in the lower inner quadrant (8,9). Less well known are the parallel data for mammographically detectable benign masses, which show an identical quadrant distribution (Table). It may well be that the tendency for both benign and malignant masses to predominate in the upper outer quadrant is due to the disproportionately large amount of residual glandular tissue in that quadrant among women above age 35–40.

Even if quadrant location is not a reliable predictor of the nature of a mass, the location of a mass can be used to guide mammographic decisions in several specific circumstances. First, any mass shown to be located within the skin will not be a primary breast carcinoma. Because skin lesions may project over parenchymal tissues on both of the standard mammographic views (10,11), the radiologist should obtain an additional tangential view of any potentially superficial mass before indicating mammographic suspicion of malignancy (Fig 1). Second, lesion location is important in the mammographic diagnosis of intramammary lymph nodes. Although intramammary nodes are found histologically throughout the breast, virtually all nodes large enough to be visualized with mammography are located in the outer half of the upper outer quadrant (12,13). Therefore, the confident radiographic diagnosis of such a lesion should not be made unless it conforms to this location. Finally, the

location of some palpable breast masses may indicate the need for additional mammography. If a palpable lesion is located so peripherally as not to be included on either standard mammographic view, then one must obtain exaggerated cranio-caudal, alternative oblique, or "lumpogram" projections to image it satisfactorily (27).

Density

Breast masses may be classified by density into either fat, water (fibroglandular tissue), or mixed-density categories. This is an important distinction since virtually all malignant breast masses are of water density, and therefore, any fat or mixed-density mass can be considered benign.

A completely fatty mass surrounded by water-density tissue will be recognized by its relatively lower density and convex margins, whereas when enveloped by fatty tissue such a mass will be identified if its thin fibrous "capsule" is imaged (Fig 2). The differential diagnosis of fat-density masses includes lipoma, fat necrosis, galactocele, and focal collection of normal breast fat that simulates a mass on mammograms. There is no clinical significance in differentiating among these benign lesions, so biopsy is not necessary for the purpose of tissue diagnosis and follow-up is not needed to assess for possible interval change (14–16). However, as an academic exercise, one can often suggest the correct histologic diagnosis: Large (greater than 2-cm) masses tend to be lipomas, the lipid-containing cysts of fat necrosis often are seen at sites of prior surgery or trauma, and galactocysts usually occur during or shortly after lactation.

Mixed-density masses contain both fat and water-density elements. One

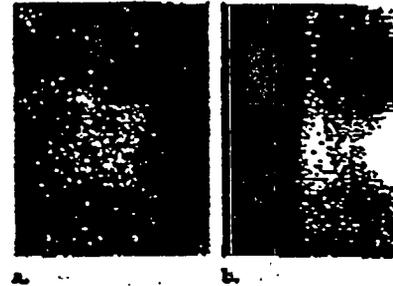


Figure 1. Skin lesion mimicking intramammary mass. Diagnosis: infected epidermal inclusion cyst. (a) Cranio-caudal projection demonstrates poorly defined mass overlying breast parenchyma. There were similar findings on lateral projection (not shown). (b) Tangential view of mass indicates its dermal location, thereby eliminating mammographic suspicion of malignancy.



Figure 2. Fat density mass. Diagnosis: lipoma. Thin radiodense "capsule" is readily visible where fatty tissue is immediately adjacent to mass (white arrow). "Capsule" not seen where dense tissue is adjacent to mass (black arrow).

such lesion is the hamartoma, otherwise known as lipofibroadenoma or fibroadenolipoma (Fig 3). Radiographic diagnosis of this benign lesion requires demonstration of a thin "capsule" at the edge of the mass, permitting one to appreciate that it contains not only water-density but also fatty components (4,17–20). The other, much more commonly en-



Figure 2. Mixed-density mass. Diagnosis: unaroma. Note thin radiolucent "capsule" demonstrating borders of mass, thereby indicating that it contains fat as well as water-density elements.



Figure 3. Water-density mass. Diagnosis: infiltrating duct carcinoma. Cancer (arrow) appears more dense than other water-density structures of similar size.

numbered, mixed-density mass is the intramammary lymph node. This kidney-shaped lesion characteristically displays a radiolucent hilus of variable size, indicating replacement at its hilus (1,4,13-15,19,21). Demonstration of the fatty hilus is crucial to mammo-

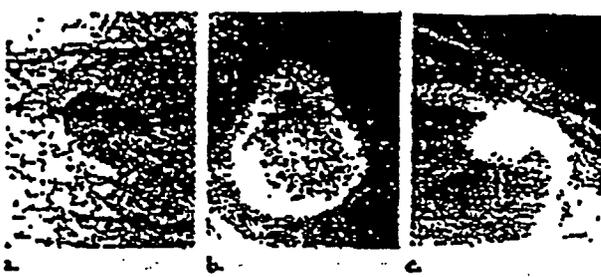


Figure 4. Mixed density masses. Diagnosis: intramammary lymph nodes. (a) Fatty hilus imaged tangentially, showing defect in contour of mass. (b) Fatty hilus imaged en face, showing central lucency. (c) Smallest mammographically visible fatty hilus (arrow) will be recognized only if imaged tangentially.

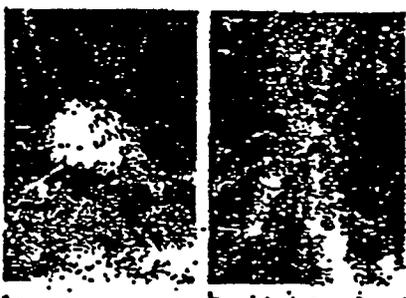


Figure 6. Stellate masses. (a) Note dense central area, irregular contour, and numerous fine spiculations radiating out from mass, representing typical mammographic features of malignancy. Diagnosis: infiltrating duct carcinoma. (b) Note relative lack of central density and several radiolucent lines radiating out from center of mass. Diagnosis: radial scar.

graphic diagnosis; the hilus will be seen as a contour defect if imaged tangentially, or as a central lucency if imaged en face (Fig 4). Intramammary nodes, like all other lymph nodes, undergo changes in response to infection, inflammation, or neoplasm. Independent of the underlying cause, the pathologic intramammary node loses its characteristically benign mammographic appearance, becoming more rounded in contour, enlarging beyond 1 cm, and no longer displaying a radiolucent hilus (1).

Water-density masses account for the remainder, and the vast majority, of breast masses. The main differential diagnosis for these lesions involves cyst, fibroadenoma, and carcinoma. When possible, mammographic differentiation is based primarily on those radiographic features discussed later in this article. However, assessment of density can also be helpful occasionally. Since some breast cancers appear to be slightly more dense than adjacent areas of fibroglandular tissue, whereas most

benign lesions do not (1,4,6,9,19,21) (Fig 5). This observation cannot be explained on the basis of inherently increased density within breast cancer; assessment with computed tomography has demonstrated lack of meaningful difference in x-ray attenuation between benign and malignant water-density tissue (22,23). Rather, the increased density of some malignancies is much more apparent than real, probably resulting from the fact that these cancers contain disproportionately large amounts of sclerotic and fibrous elements (21), causing them to flatten out to a lesser degree when vigorous breast compression is applied (9). The less compressible carcinoma therefore retains greater thickness during mammographic imaging, thereby stopping more x-ray photons and appearing to be denser than adjacent benign tissues. Note that visualization of this subtle difference in apparent density requires the use of a high-contrast screen-film recording system (1,9), vigorous breast compression (6,9), and comparison of breast structures that are approximately equal in volume (21).

Shape

Some breast masses have characteristically benign or malignant shapes. The typical cancerous mass has a stellate or starburst appearance, with an irregular contour often accompanied by fine linear strands (spiculations) radiating out from the edges of the mass (Fig 6a). Most masses with these mammographic features prove to be malignant, but not infrequently a benign lesion will also appear in a similar fashion (1,4,6,19,24), emphasizing the need to establish a tissue diagnosis of malignancy before definitive cancer treatment is begun (6). The most common benign stellate mass is caused by scarring from prior biopsy,

but the differential diagnosis also includes radial scar, fat necrosis, abscess, hematoma, and any other mass that contains substantial areas of fibrosis. Careful analysis of accompanying mammographic features may allow the radiologist to suggest one of these benign entities. For example, the radial scar usually lacks central density and has thin radiolucent lines radiating out from its middle (Fig 6b). Past or present medical history and correlative physical findings also may prove helpful, in that prior biopsy at the site of the stellate mass suggests fat necrosis, prior trauma and accompanying ecchymosis favors hematoma, and recent onset of pain, tenderness, and overlying erythema increases the likelihood of abscess. However, as a rule, none of these benign lesions can be distinguished from malignancy with sufficient reliability to avert biopsy (1,4,6,24). On occasion, if clinical suspicion of hematoma or abscess is high, repeat mammography after 1 month may be ordered to document the expected disappearance or substantial resolution of the lesion (4). Also, a stellate mass thought to represent scarring at a recent biopsy site may be followed mammographically to demonstrate stability or partial resolution (4,24).

The typical benign mass has a very different mammographic appearance, showing smooth contours and a round or ovoid shape (Fig 7). The great majority of these lesions are cysts or fibroadenomas, but many other solid tumors can also display similar radiographic findings. Occasionally, even a well-circumscribed carcinoma may have a characteristically benign appearance, at least on conventional mammograms (1,4,24). This observation has great significance, since it suggests that the mammographic features of a (water-density) mass should not be the only indicator used to arrive at a benign diagnosis (6). If such a mass is palpable, the findings of physical examination are important and traditionally take precedence in guiding subsequent management should they raise the suspicion of malignancy. On the other hand, when physical findings are benign or normal, the likelihood of carcinoma is very low, probably in the range of 1%-2% (25,26). For these lesions, several additional procedures are available to distinguish solid and complex masses from simple cysts. Palpable masses often undergo aspiration with or without cytologic analysis and/or pneumocystography,

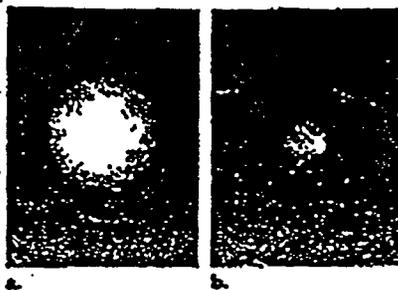


Figure 7. Masses with smooth round contour, suggesting benign nature. (a) 1.5-cm mass, containing few calcifications. Diagnosis: fibroadenoma. (b) 0.5-cm noncalcified mass. Diagnosis: simple cyst, established with US examination.

while nonpalpable lesions frequently are examined with US (1,4,6,21,27,28). Uncomplicated cysts do not require further evaluation for purposes of tissue diagnosis, since they always are benign (6). The management of solid benign-appearing masses usually involves periodic clinical and mammographic follow-up rather than biopsy (6,29).

Most mammographically visible masses cannot be classified with confidence into either a typically malignant or benign category. Many of these lesions simply are irregular in shape. Any deformity in contour should prompt further evaluation, even if other portions of the mass have typically benign features (Fig 8). A wide variety of additional mammographic techniques can be applied. Even the most smooth and rounded of carcinomas demonstrate some irregularities in contour on fine-detail images (1,21,24), especially if spot compression magnification technique is utilized (Fig 9).

The presence of lobulations within a mass often complicates interpretation. In general, the likelihood of malignancy increases as does the number of lobulations. Multinodular (knobby) masses frequently prove to be invasive duct carcinomas (Fig 10); these lesions should always undergo biopsy (21). On the other hand, the majority of nodular masses represent fibroadenomas that have only one or two gentle lobulations, often not raising sufficient radiographic suspicion of malignancy to trigger biopsy (4,21). An uncommon lobulated tumor is the cystosarcoma phylloides (giant fibroadenoma), notable mammographically for its very pronounced although not too numerous lobulations. This potentially malignant lesion usually undergoes biopsy

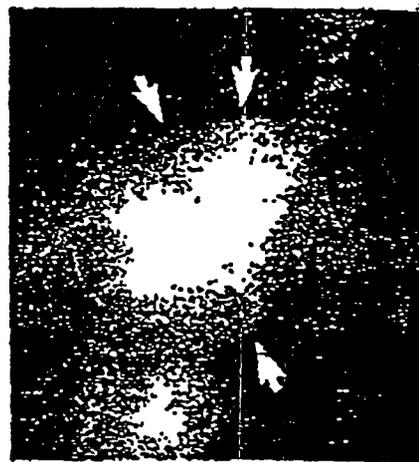
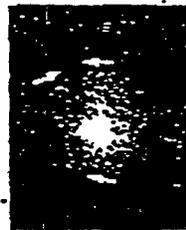


Figure 8. Mass with indeterminate features by analysis of shape. Some margins are smooth and rounded (arrows), while others are irregular. Diagnosis: infiltrating duct carcinoma.

Figure 9. Mass with generally smooth rounded contour, which on close inspection displays few fine radiating spiculations (arrows). Diagnosis: infiltrating duct carcinoma. Medullary and mucinous (colloid) carcinomas often have similar mammographic appearance.



not only because of its prominent lobulations but also due to its large size.

Clarity of Margins

Breast masses also may be classified according to the sharpness with which their margins are visible on mammograms. Such an analysis provides still another parameter to assist in radiographic diagnosis, because benign masses typically have very sharply defined margins (Fig 7), whereas the edges of most breast cancers are poorly defined (Fig 6a). However, many masses display border characteristics intermediate between those that can confidently be evaluated as benign or malignant. Commonly, a benign mass is found adjacent to areas of normal fibroglandular breast tissue, so that, although some of its margins are seen to be very well defined, others are obscured by the adjacent isodense tissue (Fig 11). This usually confounds mammographic interpretation, resulting in an equivocal or indetermi-

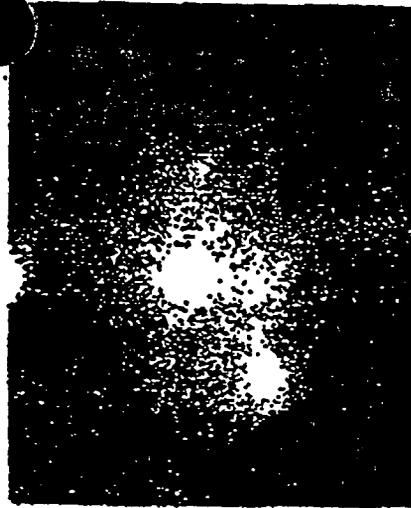


Figure 10. Mass with multiple small lobulations, prompting mammographic suspicion of malignancy. Diagnosis: infiltrating duct carcinoma.

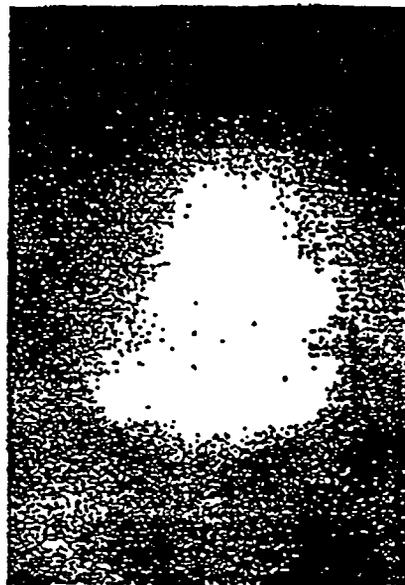


Figure 11. Mass with sharply defined margins, some of which are obscured by adjacent dense tissue, making mammographic interpretation more difficult. Diagnosis: fibroadenoma.



Figure 12. Mass demonstrating "halo sign." Note this radiolucent band (arrow) immediately external to one part of border of mass. Diagnosis: fibroadenoma.

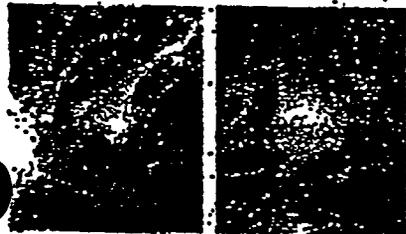


Figure 13. Water-density mass: (a) Conventional mammogram shows somewhat ill-defined margins, suggesting equivocal mammographic interpretation; (b) Spot compression magnification mammogram shows margins to be much more sharply defined and contour to be smooth and round, indicating benign mammographic interpretation. Diagnosis: benign, established by lack of interval change on subsequent screening mammograms over 7-year period.

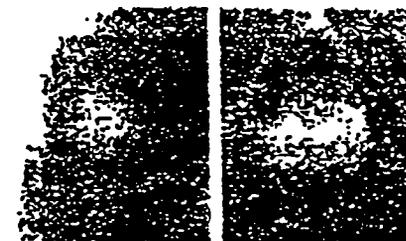


Figure 14. Water-density mass: (a) Conventional mammogram shows sharply defined margins and smooth contour, except from 6 o'clock to 9 o'clock position, suggesting equivocal mammographic interpretation; (b) Spot compression magnification mammogram shows margins to be much less well defined and contour to be much more irregular, indicating increased mammographic suspicion of malignancy. Diagnosis: infiltrating duct carcinoma.

nate diagnosis. A supplementary spot compression-mammogram may prove helpful in this circumstance if it spreads apart nearby dense structures to reveal all the borders of a mass whose silhouette is partially obscured (7,30).

Several radiologists rely heavily on one aspect of border analysis in justifying selected benign interpretations when portions of the margins of a mass are hidden by adjacent dense tissue. To them, benignity is indicated by the "halo sign," the presence of a thin, 1-mm-wide zone of radiolucency immediately external to some of the edges of the mass (1,19) (Fig 12). While the great majority of masses demonstrating this sign indeed are benign, occasional exceptions compromise its clinical value (4,21,31,32). The halo itself appears to represent a Mach band, an optical illusion of enhanced background contrast seen at any sharply defined interface (21,32). Since portions of the borders of both benign and malignant masses can be very well defined, the presence of a peritumoral halo is not pathognomonic for benign lesions (21,31,32).

With the current trend toward expanded utilization of mammography to screen asymptomatic women, we are encountering an increasing proportion of cancerous masses that display less than the fully characteristic radiographic features of malignancy

(33). As a result, most cancers now do not appear as spiculated masses but simply as nondescript lesions having poorly defined margins or irregular contour. Especially with such indeterminate findings, assessment of the marginal clarity of a given mass should be based on images of the finest detail available. The combination of spot compression and magnification techniques usually is preferred (2,7), permitting definitive interpretation for many benign and malignant masses that otherwise would receive equivocal readings (Figs 13, 14).

Interval Change

Reasonable attempts should be made to locate and obtain prior mammograms for comparison if a current examination indicates the presence of a mass. The demonstration of mammographic stability reduces the likelihood of malignancy, substantially so; if the interval between studies spans several years. Under these circumstances, continued mammographic follow-up usually is the preferred alternative to biopsy. On the other hand, the appearance or growth of a mass after an interval raises some suspicion of malignancy (Fig 15), because the breast is an involuting organ whose natural history involves progressive fatty replacement (34). Indeed, developing densities account for approximately 6% of nonpalpable cancers detected with mammography (33). It is important to realize that the radiographic demonstration of interval change is a non-specific finding, since benign masses appear de novo and grow just as malignancies do. However, despite the discovery of malignancy in only 10%-15% of such cases (34,35), subsequent management of enlarging masses usually involves prompt per-

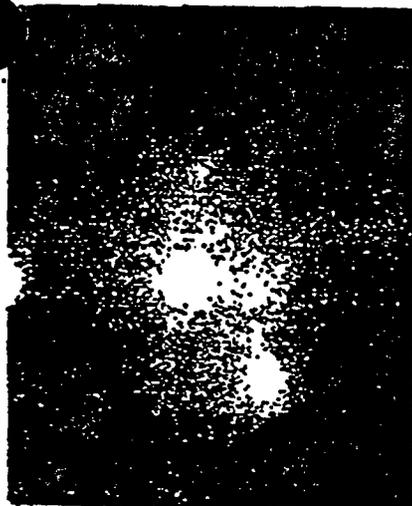


Figure 10. Mass with multiple small lobulations, prompting mammographic suspicion of malignancy. Diagnosis: infiltrating duct carcinoma.

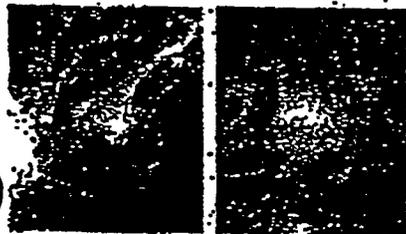


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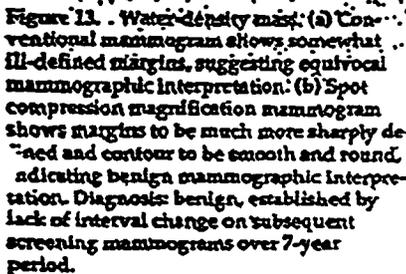


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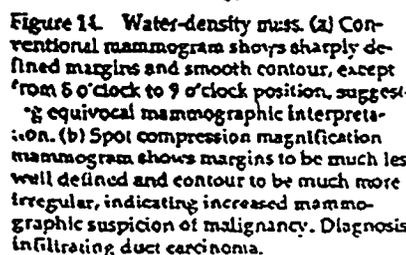


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formance of further diagnostic procedures (aspiration, US, biopsy) rather than follow-up examinations, because interval change already has occurred (6).

DISCUSSION

In most cases the step-by-step evaluation of the mammographic features of a mass (size, location, density, shape, clarity of margins, interval change) will not give clear-cut indication of benignity or malignancy (1). In fact, for any given mass several of these assessments probably will be indeterminate, perhaps even contradictory. Overall mammographic interpretation involves a synthesis of all these separate analyses, into which one must also factor the findings of physical examination and the woman's breast cancer risk profile (age, personal history of breast cancer, strong family history of breast cancer, etc.) Judicious acquisition of supplementary mammographic images, as described previously, should help convert some initially equivocal interpretations into more definitive radiographic diagnoses.

Not infrequently, several masses will be found on a mammography examination. In the great majority of these cases additional invasive procedures are not indicated, because a multiplicity of (more than two) similar breast lesions argues strongly for benignity (1,4,15,21,36). Indeed, the more masses that are identified, the less chance they represent cancer. The radiologist's task in interpreting such examinations is to seek out the one mass that has mammographic features that differ from the others, and if present, to direct further work-up specifically to the evaluation of this lesion (36). Of course, the possibility of multifocal carcinoma cannot be discounted completely, but discovery of three or more carcinomas with mammography is extremely unusual. If multiple masses having malignant radiographic features are encountered, biopsy of the largest or otherwise most suspicious lesion usually will be done first, with management of the others deferred until a histologic diagnosis is obtained. Much more commonly, multiple masses will display primarily but not entirely benign mammographic features, since portions of their margins probably will be obscured either by each other or by coexisting dense fibroglandular tissue. However, unlike the parallel situation for one or two such lesions, aspiration or US exami-



Figure 15. Water-density mass showing interval change. (a) Normal baseline mammogram. (b) Screening mammogram 1 year later demonstrates new 4-mm poorly defined mass (arrow). Diagnostic: infiltrating duct carcinoma.

nation often will not be done for multiple masses. It is difficult and time-consuming to identify each individual mass, and frequently not all of them are found to be simple benign cysts, resulting in the dilemma of having to decide which of the several mammographic masses represents the solid tumor that may require prompt tissue diagnosis. A more prudent approach to the management of multiple "probably benign" masses is periodic mammographic follow-up to determine whether one of the masses changes disproportionately in comparison with the others (15). One should also remember to add metastases to the differential diagnosis of such lesions, especially if there is a prior history of melanoma, lymphoma, or leukemia (4,37,38).

It is beyond the scope of this article to discuss the evaluation of masses that contain calcifications. Suffice it to say that some calcified masses are characteristically benign (degenerating fibroadenomas, calcified hematomas, and calcified lipid-containing cysts of fat necrosis), while others are highly suggestive of malignancy (tiny clustered linear, curvilinear, or branching calcifications within any mass) (11).

SUMMARY

The systematic mammographic evaluation of a breast mass involves independent assessments of its size,

location, density, shape, clarity of margins, and interval change from prior examination. Additional fine-detail mammograms should be obtained to facilitate this analysis, especially when an equivocal interpretation is planned. Definitively benign masses (those localized to the skin, of fat density, or of mixed density) will not require more attention. Among the remaining water-density lesions, those that have an even slightly stellate appearance should be considered suspicious for malignancy; virtually all of them will undergo biopsy. Well-circumscribed masses should next be evaluated by aspiration or US examination to establish or exclude the diagnosis of simple benign cyst. Only solid and indeterminate lesions will require further evaluation, with the ultimate decision for biopsy versus mammographic follow-up depending on the probability of malignancy determined by the combination of mammographic and physical findings as well as pertinent data from the medical history. ■

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Physician Insurers Association of America

**Breast Cancer Study
June 1995**

INTRODUCTION

The 1995 Breast Cancer Study is the latest in a series of special studies authorized to date by the PIAA Board of Directors. The delay in the diagnosis of breast cancer continues to be a leading cause of malpractice claims in terms of frequency and cost. This study was conducted for its loss prevention value to aid physicians treating female patients to recognize the factors critical in diagnosing this condition at an early stage. It is the second endeavor in which breast cancer claims were examined in detail, with the first study being published in 1990. Previous studies reviewed claims arising from the diagnosis of colorectal and lung cancer, medication errors, and, most recently, laparoscopic procedures.

These special studies are by-products of the PIAA Data Sharing Project. The Data Sharing Project began in 1985 and was developed to provide member companies with credible data on medical malpractice claims. Data elements captured in the Data Sharing System include loss causation information, expense and indemnity information, and demographics of policyholders, claimants and institutions. At the present time, twenty-one domestic member companies of the PIAA participate in the Project and these companies collectively insure more than 90,000 physicians in the United States.

The Data Sharing Project is an ongoing data collection effort to which data is reported semi-annually. As of this writing, the Project includes information on over 117,000 claims and suits, 35,700 of which are closed with total indemnity payments of over \$4 billion and an average indemnity payment of over \$139,500. Claims and suits reported in the latest semi-annual cycle ending June 30, 1994 have an average indemnity payment of \$184,000.

The most recent compilation of Data Sharing information reveals that malignant neoplasms of the female breast continue to be the condition for which a patient most frequently files a medical malpractice claim. Since 1985, 2,448 claims and suits involving breast cancer have been reported to the Data Sharing System. Breast cancer is the second most expensive condition in terms of indemnity dollars, next to claims resulting from neurologically impaired newborns. Almost 44% of all claims involving breast cancer result in an indemnity payment to the claimant. The average indemnity payment is over \$190,000 per claim during the period 1985 through 1993. Claims and suits involving this condition reported in the latest semi-annual cycle have an average indemnity payment of over \$307,000.

For the completion of this study, the survey form that was developed and utilized for the previous study was modified slightly and forwarded to member companies of the PIAA along with a request for participation. The study is intended to evaluate only those paid claims that occurred since January of 1985. This date coincides with the wide use of enhanced mammography equipment. The survey form was designed to identify the adverse incidents resulting from the delay in diagnosis of breast cancer and to identify demographic features of patients.

A total of thirty-six PIAA member companies responded to the request to participate, with thirty-three companies having claims that fit the criteria of the study. A listing of companies contributing data is found in Appendix A. These companies range from the very smallest to one of the

PIAA Breast Cancer Study**June 1995**

largest malpractice insurance companies and are situated throughout the United States. Also included is data from a PIAA member company from New South Wales, Australia. The total indemnity value is over \$146 million, and in addition, member companies spent an additional \$14 million in allocated loss adjustment expenses to handle these claims. Thus, it is apparent that breast cancer claims remain a significant source of concern for the medical malpractice insurance industry and the doctors that the PIAA member companies insure.

DISCUSSION AND CONCLUSIONS

The PIAA Data Sharing Reports indicate that the most prevalent and second most expensive condition resulting in claims against physicians is malignant neoplasm of the breast. The purpose of this study is to investigate the circumstances surrounding the high frequency and severity of claims arising from this condition. This study focuses on 487 paid cases reported by 33 PIAA member companies which specifically involve the delay in the diagnosis of breast cancer.

The results of this study are also compared to a previous Breast Cancer Study published by the PIAA in 1990. The comparative value of the studies will serve to emphasize and reinforce the problems in the diagnosis of this condition. By comparing the studies, the differences in the relative claim patterns will become apparent.

ANALYSIS OF CURRENT BREAST CANCER CLAIM DATA

The diagnosis of breast cancer continues to be a major source of loss for those physician specialties that have patients at risk for this condition. This study requested information on claims that resulted from the delay in the diagnosis, primarily to gather insight into diagnostic patterns that would result in the identification of patients with this disease.

The major findings are:

- ◆ The major focus of this study is the delay in diagnosis by the physician. The findings indicate many reasons why a delay may have occurred, several revolving around the fact that a significant proportion of the claims involved pre- and perimenopausal women, who are considered to be less likely candidates of this disease. Breast cancer is more difficult to detect and thought to be less common among younger women, which often causes a physician to be less impressed by a patient's complaints.
- ◆ More than 60% of the patients represented in this study are under the age of 50. These claims account for over 71% of the total reported paid indemnity. The average indemnity payment for those claimants under the age of 50 is more than 50% higher than for those claimants 50 and older. More than 30% of the claimants are under the age of 40, and these claims have 37% of the total reported indemnity.
- ◆ Radiologists are the specialists most frequently claimed against in this study. It is likely that radiologists are largely involved with the diagnosis of this condition in the interpretation and reporting of results of mammograms, x-ray studies, and bone scans. While members of this specialty group are less likely to have direct contact with the patient, they are still being named as defendants in these cases.

- ◆ The number of claimants reporting a positive or negative family history made no significant difference in claim frequency or in the average indemnity payment to the patient. More than 40% of the cases in this study indicated the family history as unknown. In many cases, this unknown family history could reflect the failure to ask or document this fact in the medical record. Where the family history is positive, an even more aggressive pursuit of a tissue diagnosis should be made. This may help lead to early detection of a lesion and eliminate the delay in the diagnosis, thereby giving the patient the benefit of prompt treatment and reducing the frequency and severity of claims.
- ◆ The patient most commonly found the lesion initially (60% of all cases). The physician should order follow-up studies in those cases where a patient reports a symptom that could be even remotely related to carcinoma. In all cases, it is imperative that the physician follow through until all possibility of malignancy is ruled out.
- ◆ A mass with no pain was reported in almost 50% of the cases for which the presenting symptom was recorded. However, reports of pain and tenderness, with or without the presence of a mass, were reported in more than one-quarter of the cases. This finding is significant, as pain is not commonly believed to be characteristic of breast cancer.
- ◆ In almost 80% of all cases in this study, the mammogram results were reported as negative or equivocal, when, in fact, a lesion was present. False negatives and equivocal results appear to occur more frequently in the females under 40 years of age. This large percentage of patients with either negative or equivocal results demonstrates the fact that a high index of suspicion and further testing may be warranted in diagnosing breast cancer. This is particularly important in younger women whose breasts are denser, making a lesion more difficult to detect on plain film mammography. This shows that mammography cannot be relied on as the only tool in diagnosing breast cancer. Follow-up studies may be critical, especially in cases of an equivocal mammogram result.

ANALYSIS OF COMPARATIVE RESULTS FROM PREVIOUS STUDY

In the previous PLAA study of breast cancer cases conducted in 1990, the survey forms included many of the same questions utilized in this study. This makes it possible to evaluate whether the same trends appear in both studies. Of particular interest are areas such as claimant age, use of mammography and the associated results, and payment patterns.

- ◆ Radiologists were the most frequent defendants in the current study, having been named in more than 24% of the cases. In the previous study, 11.4% of the claims were filed against radiologists. This increase is striking. OB/Gyns, at

PIAA Breast Cancer Study**June 1995**

22.8%, were the second most prevalent specialty group in this study, but were the most frequently named specialists in the 1990 study (38.6%). The percentage of primary care physicians involved in the cases changed very little, 26% in 1995, down slightly from 29% in the previous study.

- ◆ The patient discovered the lesion in 60% of the cases compared to 70.3% in the previous study where the information was known. A screening mammogram was responsible for identifying the lesion in 10.7% of the cases which is a noticeable increase from the previous study, in which a screening mammogram initially identified the lesion in only 4% of the cases.
- ◆ The mammogram had a negative or equivocal result reported in almost 80% of the cases compared to only 68% in the previous study. This result is rather surprising as it would seem that diagnostic accuracy should be better given the improving technology of mammography equipment and the increasing number of radiologists practicing solely in facilities dedicated to the diagnosis of breast disease.
- ◆ The average and median claimant age is two years higher in the current study. In this study, the average and median ages were 46 and 45 respectively. Just over 30% of the claimants are under age 40, which is a sharp decrease from the previous findings in which 40% of the claimants were under 40.
- ◆ The average indemnity payment for each case rose 36% in the five years (\$301,460 compared to \$221,524). In addition, allocated loss adjustment expenses rose almost 50% per case (\$28,700 compared to \$19,400).
- ◆ The average delay in the diagnosis was slightly higher in this study (14 months vs. 12.7 months).

RISK MANAGEMENT RECOMMENDATIONS

These recommendations are the result of the most prevalent problems described in the narrative summaries prepared for each case of the 487 cases. Risk management suggestions are provided with the intention of improving patient care and minimizing malpractice losses. The following is by no means an all-inclusive listing, however, following these suggestions may reduce liability risks. At the same time, the patient will undergo a comprehensive evaluation that will assist in a timely diagnosis.

ALL PRACTITIONERS INVOLVED IN THE DIAGNOSIS OF BREAST CANCER

- Document all patient complaints relative to the breast.
- Document any family history of breast cancer.
- Document the results of any previous mammographic studies.
- Document the recommendations for subsequent diagnostic studies and follow up.
- Remember to follow-up with other physician consultants regarding test results, etc.
- A palpable mass with a negative mammogram unequivocally requires a tissue diagnosis.
- Pregnancy should not cause delay of appropriate diagnostic studies.

PRIMARY CARE PHYSICIANS, INCLUDING OBSTETRICIAN/GYNECOLOGISTS

- Do not abandon diagnostic pursuit because you are unimpressed by the physical findings.
- Perform a thorough breast examination on each female patient as part of a physical examination, regardless of age or complaints.
- If a mass is palpated or suspected by physician, additional studies must be done to rule out malignancy.
- Be sure the patient understands the need for subsequent studies, and document this fact.
- Perform regular follow-up examinations on patients who present with complaints related to the breast.

RADIOLOGISTS

- If a mammogram results in a film of poor technical quality, repeat the study.
- If the mammogram results are equivocal, recommend a repeat study, additional views, follow-up studies, other imaging modalities, etc., as appropriate.
- Be sure an adequate physical examination was performed and documented.

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RADIOLOGISTS (continued)

- Compare the results of the present study to all previous studies that were performed.
- Promptly report your findings to the referring physician; if the patient was self-referred, the results of the study should be mailed directly to her. If there is any suspicion of an abnormality, the patient should be so advised and told to consult promptly with her primary care physician or OB/GYN.
- If you are performing a screening mammogram on a self-referred patient, be sure to do a thorough breast exam, or advise the patient of the importance of a physical breast exam to complement the mammographic study. In cases in which the patient is self-referred, you are responsible for ensuring she receives proper follow-up visits.

SURGEONS

- When a patient is referred, always perform an adequate examination and document your findings, especially when the referring physician's findings were unimpressive.
- When performing a biopsy, be sure the correct lesion is being removed, in both open and needle procedures. A specimen x-ray of the biopsy should always be obtained.
- Promptly report consultation and biopsy results to referring physician.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 76825 Global Period: XXX Current RVW: 0.98 Recommended RVW: 1.67

CPT Descriptor: Echocardiography, fetal, cardiovascular system, real time with image documentation

Source and Summary of Comment to HCFA on this service: American College of Cardiology and the American Society of Echocardiography reviewed these services and determined that they remain undervalued compared to other services within the Medicare Fee Schedule which require similar physician work effort.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32 year old mildly obese, multiparous, diabetic woman is referred by her obstetrician, who has completed her office OB ultrasound examination for verifying fetal age and growth. While completing the examination of cranial, abdominal and thoracic structures, the obstetrician has difficulty obtaining a clear 4-chamber view of the heart. The examination is undertaken at 20 weeks estimated gestational age. The physician reviews the obstetrical history and the family history regarding congenital heart disease, as well as ultrasounds sent by the referring obstetrician, perinatologist or radiologist. The pregnant woman is gowned and draped in an appropriate manner; special care is taken to assure her comfort and to avoid nausea, caval compression and dizziness caused by prolonged supine position, and immobility during pregnancy. The ultrasound probe is manipulated on the abdomen to obtain cardiac, 4-chamber, inflow and outflow views of the fetal vena cava, pulmonary artery, ductus arteriosus, aortic arch and both the atrial and ventricular septae. Views must be obtained with minimized shadowing and, depending on fetal mobility or position, windows for each individual view must be obtained widely over the maternal abdomen with readjustments of instrument settings for each view. Videotaped or digitally recorded views are reviewed by the physician for detailed interpretation and measurement. In most situations the family is informed of the general results of the examination before being dismissed. When the fetal heart is found to be abnormal, prolonged counseling about strategies is often necessary.

Description of Pre-Service Work: The physician reviews the obstetrical history and the family history regarding congenital heart disease, as well as ultrasounds sent by the referring obstetrician, perinatologist or radiologist. The pregnant woman is gowned and draped in an appropriate manner; special care is taken to assure her comfort and to avoid nausea, caval compression and dizziness caused by prolonged supine position, and immobility during pregnancy.

Description of Intra-Service Work: The ultrasound probe is manipulated on the abdomen to obtain cardiac, 4-chamber, inflow and outflow views of the fetal vena cava, pulmonary artery, ductus arteriosus, aortic arch and both the atrial and ventricular septae. Views must be obtained with minimized shadowing and, depending on fetal mobility or position, windows for each individual view must be obtained widely over the maternal abdomen with readjustments of instrument settings for each view.

Description of Post-Service Work: Videotaped or digitally recorded views are reviewed by the physician for detailed interpretation and measurement. In most situations the family is informed of the general results of the examination before being dismissed. When the fetal heart is found to be abnormal, prolonged counseling about strategies is often necessary.

SURVEY DATA:Specialty: American College of Cardiology and the American Society of EchocardiographySample Size: 24 Response Rate (%): 16 (66%) Median RVW: 2.5725th Percentile RVW: 1.57 75th Percentile RVW: 2.95 Low: 1.2 High: 4.0Median Pre-Service Time*: 10.0 Median Intra-Service Time*: 40.025th Percentile Intra-Svc Time*: 30.75 75th Percentile Intra-Svc Time*: 43.75 Low: 25.0 High: 60.0

* Time is reported in minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20.0</u>	
ICU:	<u>N/A</u>	<u>N/A</u>
Other Hospital:	<u>N/A</u>	<u>N/A</u>
Office:	<u>N/A</u>	<u>N/A</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99244	Office consultation, level 4	2.23
2)	99223	Initial hospital care, level 3	2.57
3)	99215	Office visit, est, level 5	1.51
4)	99245	Office consultation, level 5	2.96

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The mental effort of conducting a comprehensive evaluation with clinical management of a new patient requiring decision making of moderate complexity (99244) is considerable. At this level, there are some confounding co-morbid factors. The patient may have multi-system disease processes. The differential diagnosis is more complex and must be more complete. The judgement process in reaching the single best approach to resolution or treatment of the questions posed may be difficult.

Compared to the referenced E&M service (99244), physician work in performing a fetal echo evaluation is somewhat higher. A comprehensive review of clinical data and a comprehensive examination are common parts of both services. The level of complexity is somewhat higher for the fetal examination, since the fetus is very small, difficult to visualize, and the ramifications of fetal abnormalities can be profound. Considerable diagnostic skill is required to evaluate the patient and develop a plan of care appropriate to the patient's condition and required follow-up care.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The requirements for mental effort and expert clinical judgement in performing a fetal echocardiography are significant: expert conceptual judgement and ability to interpret the data; a comprehensive knowledge of the forms of congenital heart disease and their morphology and associated malformations; and, a complete understanding of the fetal cardiocirculatory physiology and the morphogenic and maturational changes inherent in cardiac growth and molding during the second and third trimesters of pregnancy. The physician must obtain enough views with enough visual clarity to avoid a false-positive diagnosis (with the possibility of choice of termination of pregnancy) or a false-negative diagnosis with the risk of missing a major cardiovascular malformation. Note: Mental effort and judgement at level 4-5, technical skill and physical effort at level 4, psychological stress at level 4. The majority of respondents indicated the work of this code has changed in the last five years, although the familiarity with the technology is stable. Basically, the patients requiring this service are increasingly complex. All agree that the vignette describes their typical patient.

Because the fetus is small and far away from the transducer and because maternal abdominal wall and uterine size may vary, all scanning maneuvers, which are already difficult during congenital heart disease echocardiography, are compounded by distance, fetal mobility and variable fetal position. When the spine is up or the head is closest to the transducer, shadowing by skeletal structures can be a major problem. Prolonging the examination often results due to needs to try different maternal positions, different window positions on the maternal abdomen, and different probe frequencies and configurations to deal with variable distance of the fetus, and varying structures in the beam path between the transducer and the fetal heart with the different views. The fine maneuvers required for scanning these small structures and optimizing their visualization clarity requires extreme spatial understanding, patience and manual dexterity in scanning technique and a very high level of understanding of physical principles of ultrasound examination and instrumentation factors of resolution, reverberation, shadowing and artifacts as determinants of imaging results.

This type of examination challenges the physician's conceptual and manual skills. The complexity of the fetal anatomy, variability of image clarity and the possible outcome of pregnancy termination when heart disease is diagnosed in utero, combine to generate considerable psychological stress for the physician. The decisions and discussions, when an unborn fetus is abnormal, are burdensome and difficult.

The College believes this service, fetal echocardiography, has a significantly higher work value than that currently assigned. Although the median survey value is 2.57, we believe a value of 1.67 is appropriate and urge the RUC to adopt this recommendation.

Public Comments

06-Jul-95

Code: 76825

1995 RVUs: 0.98

Recommended RVUs: 1.67

Ratio:

Long Descriptor: Echocardiography, fetal, cardiovascular system, real time with image documentation (2D) with or without M-mode recording,

Reference Set (y/n): N

Global Period: XXX

Frequency: 173

Impact: 119

Source: 5

Year: 94

Public Comment Letter: 288

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACC

Societies Wishing to Comment: ACR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
76825	0	0	0	100	100	0	0	50

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
76825	210	202	-1.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
76825	15.2	11.9	-1.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
76825	cardiovascular disease	8.9
	group practices	5.9
	internal medicine	4
	obstetrics/gynecology	39.6
	pediatrics	16.8
	radiology	20.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
76825			

Public Comments

06-Jul-95

250	12.5	DIABETES MELLITUS
631	12.5	OTHER ABNORMAL PRODUCT OF CONCEPTION

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
76825							
ACC	26		XXX		0.98		0.76

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
76825								
ACC	0.76	0.98		1.00	1.29	1.00	1.67	288

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
76825								
ACC	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
76825									
ACC									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
76825									
ACC				1.67	0.98				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
 FIVE-YEAR REVIEW PROCESS
 SUMMARY OF RECOMMENDATION

CPT Code: 78070 Global Period: XXX Current RVW: .51 Recommended RVW: 0.95

CPT Descriptor: Parathyroid imaging

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Middle aged person with evidence of hyperparathyroidism, who has undergone one unsuccessful neck exploration for parathyroid adenoma. Ultrasound and CT studies have not located the tumor or hyperplastic glands(s).

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology, American College of Nuclear Physicians, Society of Nuclear Medicine

Sample Size: 599 Response Rate (%): N = 168 (28.0%) Median RVW: 0.95

25th Percentile RVW: 0.80 75th Percentile RVW: 1.0 Lowest RVW: 0.39 Highest RVW: 2.25

Median Total Service Time: 15 minutes 25th Percentile Total Service Time: 10 minutes

75th Percentile Total Service Time: 25 minutes Lowest Total Time: 3 minutes

Highest Total Time: 120 minutes

Median Complexity Source (1 = least complex, 5 = most complex):

Factor	78070	78006	78018	78223	78472	Average of all References
Mental Effort and Judgement	3.0	3.0	3.0	3.0	3.0	3.0
Technical Skill and Physical Effort	3.0	2.0	3.0	3.0	3.0	2.75
Psychological Stress	3.0	2.0	3.0	3.0	3.0	2.75

Median Total Time (Minutes):

78070	78006	78018	78223	78472	Average of all References
15	10	20	19	17	16.5

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 78006	Thyroid imaging, with uptake; single determination	0.49
2) 78018	Thyroid carcinoma metastases imaging; whole body	0.95
3) 78223	Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function	0.84
4) 78472	Cardiac blood pool imaging, gated equilibrium; single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	0.98

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 78070 compares extremely well to its key reference services (78006, 78018, 78223, and 78472) with respect to intensity and time. With respect to intensity, code 78070 meets or surpasses its reference codes individually and collectively. Furthermore, its estimate of total time is comparable to the other reference procedures.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The ACR's recommended RVW for code 78070 is the survey's median value (0.95).

Nearly two-thirds of the respondents (65.1 percent) felt that the work involved in the procedure has changed over the last five years (34.9 percent did not). [See the next paragraph for a discussion of how the work involved in the procedure has changed.] In addition, the vast majority of the respondents (70.9 percent) disagreed that technology lessened the amount of work involved in the procedure. The patients undergoing this procedure have not changed, according to 63 percent of the respondents (32 percent thought that patients were more complex and 5 percent thought they were easier). The majority of the respondents (95.8 percent) indicated that the site of service remained the same (4.2 percent thought it changed to the outpatient setting). Lastly, the vast majority of the respondents (88.4 percent) agreed with the vignette.

Since the time procedure was originally valued, the physician work has changed. The patients presenting for the today have had either surgery or some other imaging modality. Therefore, there is more clinical data to consider and correlate with respect to the study's findings.

ATTACHMENT
SERVICE DESCRIPTION

Code Being Rated: 78070

Parathyroid imaging

Pre-Service:

1. Record review.
2. Prepare equipment.
3. Interview patient.

Intra-Service:

1. Verify patient positioning.
2. Review images.
3. Correlate findings with other clinical data.

Post-Service:

1. Discuss findings with patient.
2. Discuss findings with referring physician.
3. Dictate report.
4. Review/sign report.

CMD Comments

06-Jul-95

Code: 78070

1995 RVUs: 0.51

Recommended RVUs: 0.65

Ratio: 0.27

Long Descriptor: Parathyroid imaging

Reference Set (y/n): N Global Period: XXX Frequency: 3,699 Impact: 517.86

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
78070			
	78010 THYROID IMAGING	0.39	XXX
	78011 THYROID IMAGING WITH FLOW	0.45	XXX

CMD Comment:

78070 is the equivalent of doing the two reference codes (since two different isotopes are used, two different procedures with similar pre-intra-, and post-times are required).

Societies Wishing to Survey: ACNP/SNM, ACR

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
78070	34.7	7.4	21.5	70.5	8.4	7.4	10.5	10.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
78070	2312	3798	28.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
78070	22.7	23.1	0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
78070		
	group practices	3.6
	internal medicine	2.2
	nuclear medicine	16.9
	radiology	71.8

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
78070		
226	1.1	BENIGN NEOPLASM OF THYROID GLANDS
227	2.1	BENIGN NEOPLASM OF OTHER ENDOCRINE GLANDS AND RELATED STRUCTURES
242	1.3	THYROTOXICOSIS WITH OR WITHOUT GOITER
245	1.1	THYROIDITIS
246	2.9	OTHER DISORDERS OF THYROID
252	5.5	DISORDERS OF PARATHYROID GLAND
275	2.1	DISORDERS OF MINERAL METABOLISM
V72	7.6	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
78070							
ACR	26		XXX	.	0.51	.	0.51
CMD	26		XXX	.	0.51	.	0.51

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
78070								
ACR	0.51	0.51	.	1.00	1.00	1.00	1.00	299
CMD	0.51	0.51	.	1.00	1.00	1.00	0.65	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
78070								
ACR	XXX	.	.	.	.	.	.	.
CMD	XXX	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
78070									
ACR
CMD

Harvard Data:

CMD Comments

06-Jul-95

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
78070									
ACR		.		1.00	0.51				
CMD		.		0.65	0.51				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 78195 Global Period: XXX Current RVW: .70 Recommended RVW: 1.47

CPT Descriptor: Lymphatics and lymph glands imaging

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignettes Used in Survey:

- (i) Forty-two year old business person with malignant truncal melanoma; the patient is referred to determine the pathway(s) of lymphatic drainage and the precise location of the sentinel node(s).
- (ii) Sixty-six year old who has lymphedema and who is referred to determine anatomy of lymphatics in anticipation of corrective surgery.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology, American College of Nuclear Physicians, Society of Nuclear Medicine

Sample Size: 599 Response Rate (%): N = 130 (21.7%) Median RVW: 1.47

25th Percentile RVW: 1.20 75th Percentile RVW: 1.65 Lowest RVW: 0.75 Highest RVW: 7.36

Median Total Service Time: 30 minutes 25th Percentile Total Service Time: 20 minutes

75th Percentile Total Service Time: 60 minutes Lowest Total Time: 8 minutes

Highest Total Time: 200 minutes

Median Complexity Source (1 = least complex, 5 = most complex):

Factor	78195	78018	78223	78306	78465	Average of all References
Mental Effort and Judgement	3.0	3.0	3.0	3.0	4.0	3.25
Technical Skill and Physical Effort	4.0	3.0	3.0	2.0	3.0	2.75
Psychological Stress	3.0	3.5	3.0	2.0	3.0	2.87

Median Total Time (Minutes):

78195	78018	78223	78306	78465	Average of all References
30	22.5	10	16	20	17.12

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 78018	Thyroid carcinoma metastases imaging; whole body	0.95
2) 78223	Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function	0.64
3) 78306	Bone and/or joint imaging; whole body	0.86
4) 78465	Myocardial perfusion imaging; tomographic (SPECT), multiple studies, at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, qualitative or quantitative	1.46

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 78195 compares extremely well to its key reference services (78018, 78306, 78223, and 78465) with respect to intensity and time. With respect to intensity, code 78195 is comparable to the reference codes, even surpassing them in terms of technical skill and physical effort. Furthermore, its estimate of total time exceeds the other reference procedures.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The ACR's recommended RVW for code 78195 is the survey's median value (1.47).

Nearly two-thirds of the respondents (64.1 percent) felt that the work involved in the procedure has not changed over the last five years (35.9 percent did). In addition, the vast majority of the respondents (82.8 percent) disagreed that technology lessened the amount of work involved in the procedure. The patients undergoing this procedure have not changed, according to 55.1 percent of the respondents (43.5 percent thought that patients were more complex and 1.4 percent thought they were easier). The majority of the respondents (77.6 percent) indicated that the site of service remained the same (3 percent thought it changed to the inpatient setting and 19.4 percent believed it changed to the outpatient setting). Lastly, the vast majority of the respondents (92.2 percent) agreed with the vignette.

Although the survey's results suggest otherwise, there has been some changes to this procedure that have a bearing on the physician work required. The procedure has benefited from the development of improved small colloids, better imaging techniques, and the use of hand-held detectors to precisely localize sentinel nodes. Based on the results of the procedure, patients may be spared extensive lymph node resection, treatment of lymphedema may be improved, and improved localization of lymph nodes at risk for tumor spread.

ATTACHMENT
SERVICE DESCRIPTION

Code Being Rated: 78195

Lymphatics and lymph glands imaging

Pre-Service:

1. Review record.
2. Interview patient.
3. Plan procedure.
4. Equipment preparation.
5. Obtain consent.

Intra-Service:

1. Prep. area(s) for injection.
2. Injection(s) of radiopharmaceutical.
3. Monitor drainage pathways and mark nodes.
4. Review images/computer data.

Post-Service:

1. Discuss findings with patient.
2. Discuss findings with referring physician.
3. Dictate report.
4. Review/sign report.

Public Comments

06-Jul-95

Code: 78195

1995 RVUs: 0.7

Recommended RVUs: 2.00

Ratio:

Long Descriptor: Lymphatics and lymph glands imaging

Reference Set (y/n): N

Global Period: XXX

Frequency: 526

Impact: 684

Source: 2

Year: 92

Public Comment Letter: 299

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACNP/SNM, ACR

Societies Wishing to Comment:

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
78195	42.9	0	28.6	71.4	14.3	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
78195	426	488	7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
78195	39.9	25.8	-7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
78195	group practices	6.1
	nuclear medicine	27.9
	radiology	62.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
78195	172	3.6	MALIGNANT MELANOMA OF SKIN
	174	3.6	MALIGNANT NEOPLASM OF FEMALE BREAST

Public Comments

06-Jul-95

202	3.6	OTHER MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE
428	3.6	HEART FAILURE
457	3.6	NONINFECTIOUS DISORDERS OF LYMPHATIC CHANNELS
715	3.6	OSTEOARTHRISIS AND ALLIED DISORDERS
782	10.7	SYMPTOMS INVOLVING SKIN AND OTHER INTEGUMENTARY TISSUE
V72	7.1	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
78195							
ACR	26		XXX		0.70		0.70

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
78195								
ACR	0.70	0.70		1.00	1.00	1.00	2.00	299

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
78195								
ACR	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
78195									
ACR									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
78195									
ACR				2.00	0.70				

ACNP/SNM

American College of Nuclear Physicians/Society of Nuclear Medicine
GOVERNMENT RELATIONS OFFICE

MEMORANDUM

TO: Grant V. Rodkey, M.D.
Chairman, AMA RVS Update Committee (RUC)

John Tudor, Jr., M.D.
Chairman, RUC Five-Year Review Subcommittee

FROM: The American College of Nuclear Physicians (Terence Beven, M.D., RUC Advisor)
The Society of Nuclear Medicine (Kenneth McKusick, M.D., RUC Advisor)

DATE: August 21, 1995

SUBJECT: Extraction of Code 78195 (Lymphatics and lymph glands imaging) from the RUC
Consent Calendar

In keeping with the report from Workgroup 5, the American College of Nuclear Physicians and the Society of Nuclear Medicine would like to extract code 78195 from the consent calendar so that additional information on this procedure can be provided.

Lymphatics imaging is a procedure undergoing change. A few years ago, the study consisted of only imaging the lymph nodes. Today, in addition to basic imaging, the identification of the sentinel node is of primary importance. (See attached article.) The ability to localize the sentinel node is made possible through improved small colloids, better imaging techniques, and the use of hand-held detectors; all of which add to the physician work required. The procedure also is used to map out obstructed lymphatics in cases of lymphema.

Another significant factor in the physician work associated with the procedure has to do with the administration of the radiopharmaceutical. In fact, four to six separate intradermal injections are required, all of which are performed by the physician and not billed additionally. (In a mini-survey of nineteen physicians experienced with the procedure, eighteen indicated that they performed the injection.) The same survey estimated that the median time required to do just the injections was 18 minutes. These injections are performed at the tumor site, either before or after excision. In melanoma cases, the injections are made in highly visible parts of the patient's body (e.g. face, arm, leg). The patients, therefore, are upset over having cancer and concerned over the injections. As a result, there is a sizable amount of patient interaction.

Although there are no other lymphatics codes in Nuclear Medicine for comparison, one reference procedure that shares some of the basic characteristics of code 78195 is code 78630 [Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography], which has an RVW of 0.68. Like code 78195, the physician performs the injection. However, the injection for code 78630 is separately reportable using a code like 62289 (Injection of substance other than anesthetic, contrast, or neurolytic solutions; lumbar or caudal epidural), which has an RVW of 1.64. The imaging and injection codes, when combined, bring the total number of relative values to 2.32. Although the injections for code 78195 are more numerous than that for 78630, they also are less intensive. Therefore, the additional 0.77 RVUs requested for code 78195 (current RVW = 0.70) are justified by the injections alone.

Thank you for your consideration of this request.

Lymphoscintigraphy in High-Risk Melanoma of the Trunk: Predicting Draining Node Groups, Defining Lymphatic Channels and Locating the Sentinel Node

Roger F. Uren, Robert B. Howman-Giles, Helen M. Shaw, John F. Thompson and William H. McCarthy

Nuclear Medicine and Diagnostic Ultrasound, Camperdown and Sydney Melanoma Unit, Royal Prince Alfred Hospital, Sydney, New South Wales, Australia

Lymphoscintigraphy was performed in 209 patients with high-risk melanoma of the trunk referred to the Sydney Melanoma Unit and considered for lymph node dissection. Lymphoscintigraphy accurately defined the draining lymph node groups and was 94% sensitive in detecting draining sites that contained metastases. When combined with the clinical finding of palpable lymph nodes, the sensitivity rose to 98%. Most patients showed lymph drainage to one or two node groups and only 22 patients showed drainage to 3 or more node groups. The major lymph channels could also be marked on the skin prior to incision/dissection. Most patients had multiple draining lymph channels and these often diverged significantly from each other in the path to the draining node group. The number and location of interval nodes could be determined and marked on the skin. These and the major lymph channels could thus be excised at the time of surgery. Unusual drainage patterns were sometimes seen; for example, three patients displayed a new lymph pathway with direct drainage from the back anteriorly to the para-aortic nodes. The location of the sentinel nodes in each draining lymph-node group could also be marked on the skin prior to surgery, enabling quick and accurate identification of this node, using the blue-dye technique if biopsy were to be performed. These findings lead us to recommend lymphoscintigraphy prior to wide local excision in patients with truncal melanoma who are candidates for surgery. Lymphoscintigraphy results will help plan surgery and lead to minimum surgical intervention, consistent with effective surgical management.

J Nucl Med 1993; 34:1435-1440

In patients with clinically impalpable lymph nodes and melanomas thicker than 1.5 mm, micrometastases are detected in nodes excised during elective lymph node dissection in up to 37% of patients (1). Consequently, prognosis of high-risk melanoma of intermediate thickness is im-

proved by early lymph node dissection (ND) performed at the same time as wide local excision (WLE) (2-5).

The difficulty with trunk melanomas is determining which lymph node groups are potential sites of micrometastases and candidates for surgical removal. Many studies using lymphoscintigraphy (LS) have shown the lymphatic watershed concept based on Sappey's work (6) to be incorrect in approximately half the patients (7-9). Clinical judgment based on this concept is thus of no practical use in an individual patient when a node dissection or biopsy is contemplated. LS has itself been used to define which node groups drain a cutaneous lesion, and surgical correlation in some patients has validated this approach (7). The number of patients in such studies has always been small.

The aims of our study were to (1) use LS prospectively prior to WLE and ND in order to define the draining lymph node groups in a large number of patients with truncal melanoma; (2) determine its accuracy in predicting the location of melanoma metastases to lymph nodes; (3) define the number and distribution of the major lymph channels involved in each patient; (4) document the degree of divergence from each other and the expected path to the draining node group; (5) define the number and location of any interval nodes and (6) determine if LS could be used to locate the sentinel node or nodes in each of the draining lymph node groups. The sentinel node is the first to accept and retain the tracer in each draining lymph node group.

METHODS AND MATERIALS

From October 1986 to July 1992, cutaneous LS was performed on 209 patients—159 males and 50 females. Technetium-99m-antimony sulphide colloid ($^{99m}\text{Tc-Sb}_2\text{S}_3$) was prepared on site for each patient, using kits supplied by the Royal Adelaide Hospital radiopharmacy. Technetium-99m was supplied daily by Australian Radioisotopes and produced in the nuclear reactor at Lucas Heights in Sydney. Particle size varied from 3 to 12 μm (10,11). Multiple, small-volume (0.1 ml) intradermal injections were used to surround the biopsy excision site or, in some patients, the primary lesion. All studies were performed prior to wide local excision, which is essential to a good quality study. Specific

Received Nov. 3, 1992; revision accepted Apr. 27, 1993.
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activity of the dose varied from 50–70 MBq/ml, so that each injection contained 5–7 MBq. Between 4 and 14 injections were used, although most patients received 6–8 injections. This delivered a radiation dose of 0.2–0.5 Sv to the injection site. This injection site was completely excised as part of the WLE in all patients within one week.

Careful technique was required to ensure accurate intradermal injections and avoid contamination of the rest of the skin, which greatly complicates interpretation, especially in the definition of interval nodes. A large, waterproof incontinence sheet was used to cover the patient's trunk and a small window cut in the sheet to expose the lesion. Gloves were essential. In addition, because the intradermal injection was under pressure, swabs were placed over the area before the needle was withdrawn to prevent spraying the radionuclide over the patient and provider.

All scans were performed using a large, rectangular field-of-view digital gamma camera (Toshiba 90B) with a low-energy, high-resolution collimator. Each scan view was collected over 10 min. Scanning was commenced immediately and the major lymph channels defined at this stage. The digital camera was important so that the computer image could be enhanced to reveal even the faintest channels, which were drawn on the skin using an indelible marker after the channel had been followed with a radioactive source. We used a drop of ^{99m}Tc in the tip of a needle cap.

Calibrated rulers were provided surgeons so patient measurements could be checked directly with patient scans at the time of surgery. Delayed scans were performed at 2.5 hr and anterior views of the axillary and inguinal areas obtained. If a lesion was high on the back, a posterior view was obtained to check drainage to posterior triangle nodes. Lateral or oblique views were done, if necessary, to define the anterior or posterior position of a node or clarify unusual drainage patterns. Computer enhancement of the image was important, and any discernible activity above background in recognized node group was regarded as a positive finding on delayed scans. Interval nodes were said to be present if focal uptake along one of the lymph channels in early scans was seen as a persisting focal area of uptake in the same spot on delayed scans.

In the last 6 mo of the study, the skin overlying the sentinel node or nodes was marked with an indelible pen for each node group receiving lymph flow from a lesion site. The sentinel node was the first draining lymph node to accumulate the tracer; in delayed images it was the node with the most activity because of significant hold up of colloid particles in the lymph nodes. The more proximal nodes showed less and less activity compared with the sentinel node. Accurate marking of the sentinel node required considerable care and imaging at several angles to avoid parallax error. The marking procedure must be performed with the patient in the normal position for surgery. In the case of axillary nodes, this is supine with the arm at right angles to the body. If this varies, the skin mark will not overlie the node. At surgery, patent blue is injected intradermally at the lesion site (1) and a small incision made at the site of the marked sentinel node, identified with the aid of blue dye.

One of us reported the scans at the time of the study. To test reproducibility of the reporting method for determining drainage sites, the first 51 patients, sorted in alphabetic order, were re-read by two of us separately, without knowledge of the clinical history, physical findings, original report or the other physician's new report.

Wide local excision with or without split-skin grafting was performed on all patients; ND also was performed, unless LS

TABLE 1
Lymph Drainage

Node groups	Patients
1	88 (42%)
2	99 (47.5%)
3	19 (9%)
4	2 (1%)
5	1 (0.5%)

revealed flow to three or more node groups, or the patients refused such surgery or some other contraindication to surgery existed. Lymph nodes excised surgically were examined histologically by hematoxylin and eosin staining to determine the presence of metastatic melanoma.

Patients were followed at regular intervals at the Sydney Melanoma Unit and further resection with histology performed if palpable nodes developed.

RESULTS

Lymphoscintigraphy Reproducibility

The reproducibility study showed 84 positive lymph node groups in 51 patients. Both physician readers agreed on 83 of the 84 node groups. In one patient with a lesion high on the back in the mid-line at the nape of the neck, both agreed there was flow to the supraclavicular node groups but disagreed about a small node in the posterior triangle close to the lesion site.

PATIENT STUDIES

Node Groups

Lymph drainage patterns in the 209 patients are summarized in Table 1. One hundred and eighty-seven patients (89%) had drainage to one or two node groups and were potential candidates for ND.

Drainage to the different node groups is described in Table 2. One hundred and twenty patients had drainage to one axilla; 73 had drainage to both axillary node groups. Flow to at least one axilla thus occurred in 193 patients (92%). Three patients, all of whom had lesions in the loin, displayed an unusual drainage pattern. These patients

TABLE 2
Draining Node Groups

Site	Patients
Right axilla	126 (60%)
Left axilla	141 (67%)
Right supraclavicular	16 (8%)
Left supraclavicular	21 (10%)
Right inguinal	11 (5%)
Left inguinal	17 (8%)
Right posterior triangle	5 (2.5%)
Left posterior triangle	7 (3%)
Para-aortic	3 (1.5%)
Right cervical	3 (1.5%)
Left cervical	4 (2%)
Submental	1 (0.5%)
Internal mammary	1 (0.5%)

showed drainage to the axilla or groin as well as a dominant channel passing posteriorly, medially and superiorly to the midline until, at the level of the upper abdomen or the inferior mediastinum, the lymph channel passed anteriorly to the para-aortic area. Activity then passed superiorly and tracer was seen in the thoracic duct on delayed scans (Fig. 1). Another patient with an umbilical lesion showed drainage to the left axilla and the right internal mammary chain (Fig. 2).

Lymph Channels

A total of 592 major lymph channels were seen draining the lesion site in the 209 patients with an average of 2.8 channels per patient. The number of channels varied from 1 to 7, and only 33 patients (16%) had one lymph channel draining to the regional node group. The remaining 176 patients averaged 3.2 channels per patient. Only 40 patients (19%) had channels that passed straight to the draining node group along the expected path; 23 of these had only one major lymph channel. Thus, only 16 of 176 patients (9%) with multiple lymph channels showed straight-forward drainage to a relevant node group. One hundred and sixty patients with multiple lymph channels showed some divergence of channels on their way to the lymph node group. Ten patients with only one channel showed divergence from the expected pathway up to a maximum of 4 cm. In patients with multiple channels, 88 showed a divergence of 5 cm or greater, 22 a divergence of 10 cm or

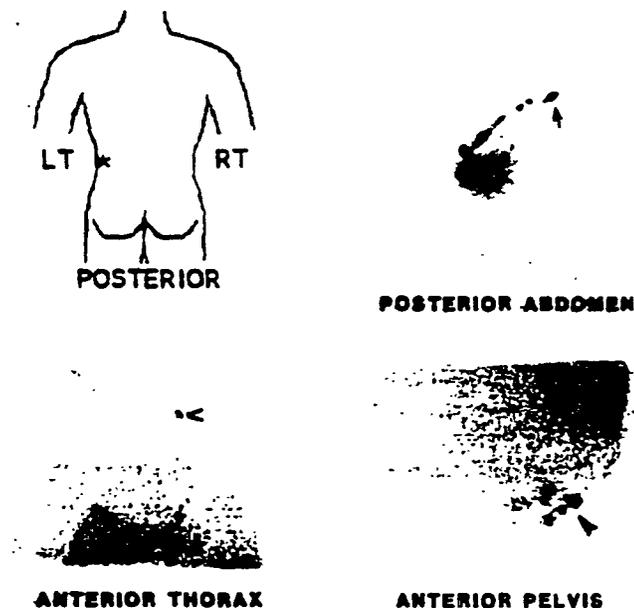


FIGURE 1. Patient with left loin lesion has lymph drainage to left inguinal nodes and para-aortic nodes. The early study posteriorly over the abdomen shows two dominant channels passing superiorly toward midline. Activity was seen in the para-aortic area at this time and on the delayed Anterior view of the thorax (small arrow). Activity was also seen in upper thorax just to the left of midline (open arrowhead) in the thoracic duct region. Delayed scans over the pelvis anteriorly show drainage to the left inguinal nodes (small arrowhead). Three patients showed such para-aortic drainage.

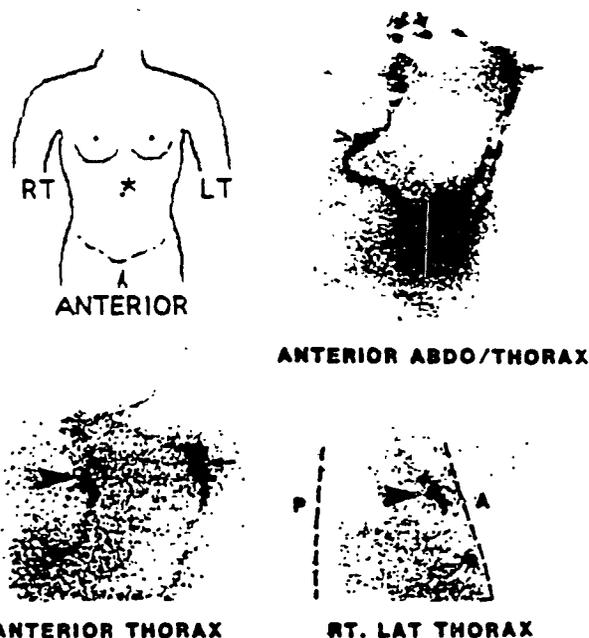


FIGURE 2. Patient with lesion just above and to the left of the umbilicus and with lymph drainage to the right internal mammary chain and the left axilla. Early dynamic phase of the study performed anteriorly over the abdomen and thorax shows dominant channels passing superiorly to the left axilla (small arrow) but also a dominant channel passing superiorly to the right before it turns once more to the left and meets an interval node (open arrowhead). The channel then enters the right internal mammary chain and continues superiorly. Internal mammary lymph nodes can be seen in the anterior and right lateral view of the thorax (large arrowhead). Two small bold arrows on the anterior view of the abdomen and thorax superiorly point to markers for manubrioclavicular joints.

greater and 3 a divergence of 15 cm. The path to draining node groups varied greatly from patient to patient, as did the number of channels draining what appeared to be identical sites on the skin in different patients (Fig. 3).

Interval Nodes

Seventy-seven interval nodes were detected in 45 of 209 patients with an average of 1.7 nodes per patient and from 1 to 7 interval nodes in each patient. Twenty-nine patients had only one interval node. Of the remaining 16, an average of 3 nodes per patient was detected.

Sentinel Nodes

Over the last 6 mo of the study, nodes were marked in 18 patients, involving 29 separate draining node groups with one sentinel node.

Initial Surgery

In 22 of 209 patients, lymph drainage to 3 or more node groups was identified (Table 1), and 20 of these patients had WLE only. Forty-eight patients refused node dissection or had some other contraindication, and had WLE only. The remaining 141 patients had WLE and ND within one week of LS. In 30 patients there were 34 draining node groups that showed metastases.

Lymphoscintigraphy correctly predicted lymphatic

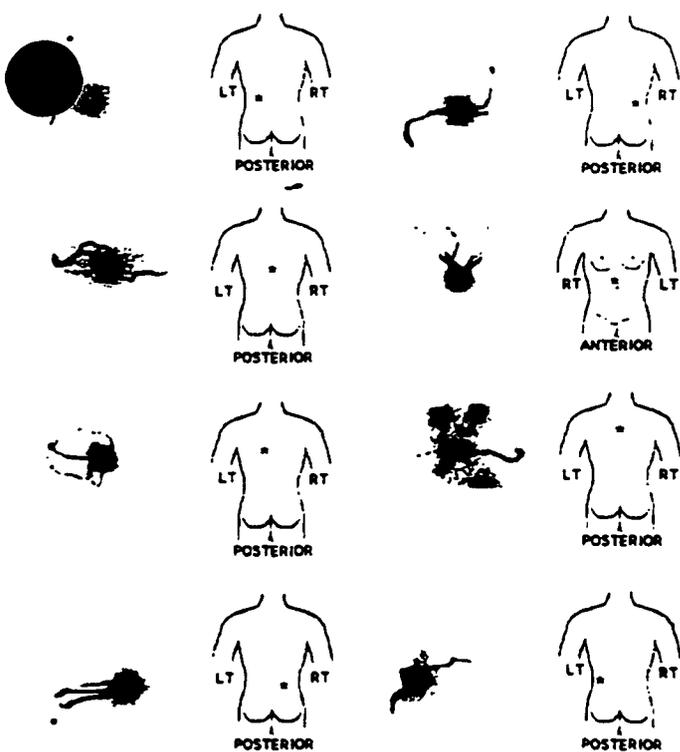


FIGURE 3. Figure illustrates the large variation in the pattern and number of draining lymph node channels. The early phase image is on the left in each case, with the position of the lesion marked on the corresponding torso to the right. Lesions in similar sites in different patients have dramatically different lymphatic drainage, which the study consistently reinforced. If an incisional dissection is performed with the intent to remove major lymph channels and interval nodes, LS information would appear essential.

drainage to 32 of the 34 sites. Of the two incorrect cases, the first patient had a lesion in the low back just to the left of midline and palpable nodes in the right inguinal area. The early LS showed a dominant channel passing to the left. Despite activity in the right and left inguinal areas on delayed scans (left more than right), the scan was misinterpreted and drainage diagnosed to the left inguinal area only. In view of clinical findings, the surgeons ignored scan results and performed a node dissection on the right groin at the site of the clinically palpable nodes and found metastases to multiple nodes in the groin, which might explain less uptake in the right inguinal nodes than in the left. Both physicians correctly reported bilateral inguinal drainage in a subsequent re-read as part of the reproducibility study.

The second patient had a lesion in the right loin posteriorly and laterally. LS showed drainage to the right axilla only. Nodes were clinically palpable in the left axilla and contained metastases at surgery. Even in retrospect no activity could be seen in the left axilla on the LS study.

Among 18 patients with marked sentinel nodes one patient's sentinel node contained a tumor; the other 13 nodes were normal. Sentinel nodes in the remaining 17 patients were normal.

Subsequent Follow-up

In 14 patients, 17 node groups subsequently developed metastases. Sixteen sites originally were predicted on LS to be potential sites of micrometastases. One patient with a lesion on the upper back to the right of midline showed dominant channels passing to the right axilla, with a small truncated channel passing superiorly and to the left for 3-4 cm. Delayed scans showed activity in the right axilla only. In retrospect, there may have been a faint trace of activity in the left axilla on the anterior view. At the time of the study, there were no palpable nodes in either axilla and, because of age, the patient received a WLE only. The course of disease was extremely rapid: Metastases developed in both axillary node groups within 5 mo and the patient died with bone metastases 18 mo after WLE.

DISCUSSION

The reproducibility study shows that interpretation of LS studies is reproducible to an acceptable degree with 99% agreement. It is reasonable to expect a similar accuracy among other nuclear medicine physicians; detecting the presence of activity as a positive finding is much easier than detecting decreased activity as a positive finding. The most difficult area for interpretation is around the neck; lateral and superior oblique views may be required here.

Axillary Drainage

We have shown that most patients (92%) with truncal melanoma have drainage to at least one axilla. Slightly more than half (58%) have more than one draining node group, although only 10.5% have drainage to three or more node groups. Our study reemphasizes the extreme variability of lymphatic drainage in individuals, which makes general rules inappropriate when predicting draining groups clinically (Fig. 3). Many patients showed surprising drainage across the midline, even when the lesion site was quite lateral. Lesions do not have to be near the midline, Sappey's line or the shoulder to have ambiguous drainage.

We also described a small group of patients who displayed unusual drainage patterns. Three included para-aortic drainage (12), which has not previously been described. Since completing the study, we have seen two more patients with this drainage pattern. We also have seen a patient with internal mammary drainage. Norman et al. (8) recently attempted to redefine lymph drainage patterns and enlarge the ambiguous drainage zone in which they advise LS. However, our experience favors LS in any patient with truncal melanoma considered for ND, regardless of the site of the lesion.

Sensitivity of Lymphoscintigraphy

The sensitivity of LS in detecting drainage sites that may contain metastases is 94%, or 96% if the one obvious misinterpretation is removed. The two remaining false-negative cases indicate that some node groups do not accumulate sufficient tracer to be detected with this technique, although they are potential drainage sites. If LS were combined with clinical findings of palpable lymph nodes, there

would have been 98% sensitivity. This overall degree of sensitivity means that LS can reliably be used prospectively to guide surgical intervention in patients with truncal melanoma. It removes the uncertainty associated with clinical judgment regarding node groups that contain micrometastases, thus limiting surgical resection to only those node groups that are potential sites of spread.

It has been postulated that melanoma metastases can block the lymph channels and replace the lymph nodes (8), causing nonvisualization of potential drainage sites on LS. This was not a significant problem in this study; in fact, good channels were sometimes seen despite clinically obvious, in-transit metastases in the lymph channels (Fig. 4).

Mapping Drainage Channels

We mapped the major lymph drainage channels by drawing the path of the channels on the patient's skin. This dramatically demonstrates great variation in the distribution of the draining lymph channels from patient to patient even when the lesion site is almost identical (Fig. 3). Early in the study, it was obvious that lymph channels often took a tortuous path to the draining lymph node group, indicating that an incision to the node group along the usual path would frequently miss much of the channel. If an incision is to be performed with intent to remove the major lymph channels and any interval

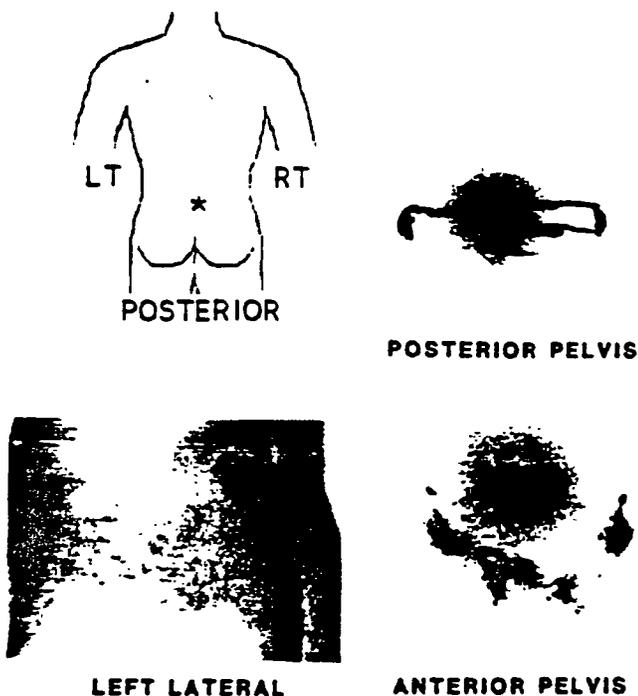


FIGURE 4. Patient with visually obvious metastases in major lymph channels passing from low back in midline to inguinal regions bilaterally (left lateral photograph). The major lymph channels, despite presence of intransit metastases, were clearly visualized on LS in the early dynamic phase performed posteriorly over the pelvis. On the delayed image anteriorly over the pelvis, little activity was seen in the inguinal nodes and most of the tracer remained in the lymph channels, suggesting that the rate of lymph flow was reduced by the metastases.

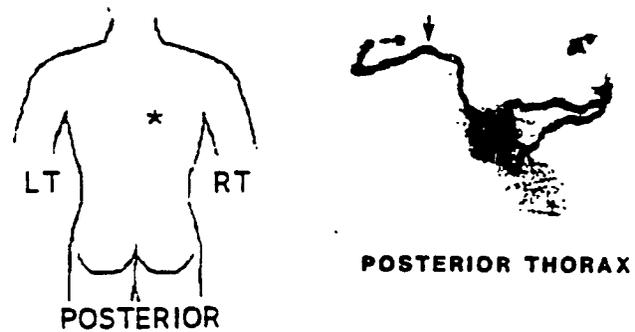


FIGURE 5. Patient with lesion on the mid back to the right of midline. Early dynamic phase performed posteriorly over the thorax shows two dominant channels passing to the right axilla and a tortuous single dominant channel passing to the left. The channel takes a superior path before turning toward the left axilla. An incision was performed on the left without exact correlation with the LS findings and a narrow strip of tissue removed followed by primary closure. The strip was below the actual path of the channel on the left; an intransit metastasis developed later at the site of the original high channel on the left (arrow).

nodes, it would be important to define the exact location of these structures. Drawing the major lymph channels on the skin demonstrates the practicality of performing an effective incision. In patients with a single dominant channel only, one can excise a thin strip containing the lymph channel, with primary closure. In patients with multiple divergent channels, a much wider resection, possibly with grafting, may be necessary. Figure 5 illustrates this point well. It was this case that led us to change from simply supplying the surgeon with LS films and a calibrated ruler, to actually drawing the path of the major lymph channels on the patient's skin with an indelible pen.

Locating the Sentinel Node

During the last 6 mo of the study we marked the sentinel node in each draining node group. This has proved to be one of the most useful aspects of LS; in the 6 mo since completion of the study, we performed sentinel node marking in another 100 patients. Locating and examining the sentinel node makes sense: If the sentinel node is normal, the likelihood that other nodes will contain metastases is low. A more radical node dissection can be avoided, with little chance that micrometastases will be missed.

LS speeds up the location of the sentinel node using the dye technique and identifies patients with interval nodes between the lesion site and the draining lymph node group. This approach is less technically demanding than dissecting the lymph channels (1).

Using LS to locate the sentinel node is also relevant for melanoma on the upper and lower limbs. Screening the node group by removing only the sentinel node should markedly decrease the incidence of lymphedema if the node is negative and a radical dissection can be avoided. Surgical resection was generally not done if there were drainage to more than two node groups. With the ability to mark the sentinel node, multiple sentinel node biopsies can be performed in different node groups, with radical dissec-

tion confined to groups with metastases in the sentinel node. The approach makes surgery available to more patients.

Great care should be taken in marking the sentinel node or nodes: The LS technique and multiple-orthogonal views must be used to avoid parallax error when marking the node site on the skin. The patient must also be in the same position as that used for surgery.

CONCLUSION

This study demonstrates that LS makes available considerable information to assist surgical management of patients with melanoma of the trunk. It can accurately define node groups draining the lesion site and identify sites of potential micrometastases in patients who do not have palpable lymph nodes. The number of node groups draining the lesion site may determine if surgery is practical. The number and actual path of the draining lymphatic channels can be defined and marked on the patient's skin prior to surgery; continuity dissection includes all of the major lymph channels and any interval nodes.

The sentinel node in each draining lymph node group can be marked on the skin, allowing rapid location of the sentinel node during surgery using the blue-dye technique. Patients who have a negative sentinel node may be spared a radical-node dissection and will have only a small incision over the sentinel node itself. We have confirmed previous studies that demonstrate great variability of lymph drainage in individuals and have also shown a new drainage pathway from the back to the para-aortic nodes. These findings lead us to conclude that LS is indicated in any patient with melanoma of the trunk who is being considered for surgical resection of the lymphatics and lymph nodes.

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**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Cardiology and Interventional Radiology

The RUC considered comments submitted by the Society of Cardiovascular and Interventional Radiology (SCVIR), the Society of Critical Care Medicine (SCCM), and the American College of Cardiology (ACC) on twenty-five cardiology and interventional radiology procedures.

SCVIR reported to the RUC that it did not conduct a RUC survey. Instead, SCVIR sent a survey containing all of the interventional radiology codes to 60 interventional radiologists which asked the physicians to evaluate the 1995 RVU for each code and select those codes that they believed were misvalued. For the codes selected, the respondents were instructed to indicate which CPT code they felt more accurately described the service in terms of time and intensity. These responses were then evaluated by a small working group formed by SCVIR consisting of physicians that are familiar with CPT, RBRVS, and the RUC process. Those codes that were identified by the working group, and misvalued were the codes that the society commented upon. In their comments to HCFA and during the RUC presentation, SCVIR mentioned that the physician work for vascular ultrasound studies is equal to all other diagnostic ultrasound services including those in the abdomen, chest, pelvis, retroperitoneum, and heart. The relative value recommendations are based on values for either "limited" or "complete" ultrasound exams in those areas.

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
35470	Repair arterial blockage	8.63	8.63	The CMDs note that HCFA's objective has been to pay the same amount for open and percutaneous angioplasties, atherectomies, and stent placements. However, when percutaneous procedures are reported, a code for access to the vessel (36011 - 36012 and 36215 - 36248) and a code for radiologic interpretation (75960, 75962 - 75968, 75978 and 75993 - 75996) are reported in addition to the code for the definitive procedure. For example, for code 35474[Transluminal balloon angioplasty, percutaneous; femoral-popliteal] the physician can also report 36246[Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family] and 75962[Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation]. In contrast, for an open procedure such as 35456[Transluminal balloon angioplasty, open; femoral-popliteal], the physician would only report one code.	The SCVIR explained that open revascularization procedures are typically done by surgical arteriotomy (or venotomy) as an adjunct to the performance of bypass procedures. For example, angioplasty of the iliac artery would be done in order to improve inflow for a subsequent femoral-popliteal bypass. Open angioplasty is also performed as a substitute for percutaneous angioplasty, atherectomy, or stenting, or open angioplasty is performed by direct percutaneous puncture of the artery. SCVIR contends that open vascular recanalization techniques are legitimate techniques when they are used by at the time of surgery either in an adjunctive manner or in a situation in which percutaneous access is impossible or too dangerous. Further, SCVIR contends that the utilization of open angioplasty when percutaneous techniques should be used is inappropriate since it typically involves more cost and subjects patients to the additional risk of general anesthesia. Thus, the use of the open percutaneous revascularization codes is necessarily limited to a relatively small group of patients with highly specific circumstances, usually those in which surgical bypass is being used. SCVIR also noted that for cases of noncoronary intervention, angioplasty is described separately from the arterial or venous access and the interpretation of the procedure. In the case of coronary angioplasty, a single CPT code is used to describe the entire activity including access to the vessel.	2
35471	Repair arterial blockage	10.07	10.07			2
35472	Repair arterial blockage	6.91	6.91			2
35473	Repair arterial blockage	6.04	6.04			2
35474	Repair arterial blockage	7.36	7.36			2
35475	Repair arterial blockage	9.49	9.49			2
35476	Repair venous blockage	6.04	6.04			2
35490	Atherectomy, percutaneous	11.08	11.08	The CMDs contend that the percutaneous procedures are, therefore, overvalued in relation to the similar open procedures. The CMDs note that the exact amount of overvaluation depends on the RVUs for the primary procedure, the code that would be used to report the access, and the radiologic supervision and interpretation codes.	2	
35491	Atherectomy, percutaneous	7.61	7.61		2	
35492	Atherectomy, percutaneous	6.65	6.65		2	
35493	Atherectomy, percutaneous	8.10	8.10		2	
35494	Atherectomy, percutaneous	10.44	10.44		2	
35495	Atherectomy, percutaneous	9.49	9.49		2	
37205	Transcatheter stent	8.28	8.28		2	
37206	Transcatheter stent	4.13	4.13	2		

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93000	Electrocardiogram, complete	0.17	0.17	CPT codes 93000 and 93010 were identified as overvalued by the CMDs. The CMDs noted that the interpretation of the majority of ECGs involves relatively few parameters in comparison to history and physical examination. They also noted that the intra-service time of this procedure which has been directly measured and reported in literature is approximately one minute. They also noted that physicians have been observed to read thirty to forty ECGs in one hour.	The specialty societies noted that the physician does the interpretation for this procedure. Although ECGs are interpreted by computer, particularly in the hospital setting, these results are "over read" by a physician. This code was surveyed by ACP and the survey median was 0.20. Although this value is slightly higher than the current value of the code the specialty society recommended maintaining the current value of the code at 0.17. The RUC noted that the Harvard time was 8 minutes for 93000 and 5 minutes for 93010. The specialty societies reported a median intra-service time of 5 minutes for both procedures. The RUC recommended maintaining the current values for these codes.	2
93010	Electrocardiogram report	0.17	0.17			2
93278	ECG/signal-averaged	0.35	0.25	This code was identified as overvalued by the CMDs. The CMDs noted that the physicians simply interpret computer generated data and this represents less physician work than the reference codes 71020[Radiologic examination, chest, two views, frontal and lateral] (0.22) and 93010[Electrocardiogram, routine ECG with at least 12 leads; interpretation and report](0.17).	The specialty societies agreed that this service may be overvalued. However, while they agree that 93278[Signal-averaged electrocardiography (SAECG), with or without ECG (0.35)] is not twice the physician work of a standard 12-lead ECG [93010(0.17)], it does involve more physician work than 93010. They recommended a value of 0.25 for this procedure which also represents the survey median. Based on the survey data of the specialty society, the RUC recommended accepting the specialty society recommendation of lowering the RVU for this procedure to 0.25.	3

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93307	Echo exam of heart	0.78	1.06	In their comment letter to HCFA, the specialty society noted that while many of the echocardiography procedures in the Medicare Fee Schedule have been reviewed, and in some instances revised, it is apparent that several echocardiography services including 93307[Echocardiography, real-time with image documentation (2D) (with or without M-Mode recording); complete], continue to be undervalued in comparison to other services that require similar physician work effort.	<p>The specialty society reported that the field of echocardiography has changed significantly in the past five years, in both clinical utility and diagnostic complexity. Although the technical innovations of the past five years have made this an easier service to perform, the patients that require this service are more complex, which has resulted in an increased amount of physician work. The physicians are viewing and making judgements on constantly moving objects, which increases the possibility of misinterpretation. Often this service is provided in acute care settings or emergency situations which increase physician stress. The information derived from this study is used in the development of critical management decisions. The risk of misdiagnosis, in both emergent and non-emergent situations, can lead to potentially fatal events.</p> <p>Although the RUC agreed that the code is undervalued based on the amount of physician work that is required to perform this study and the increased amount of information that can now be derived from echocardiography, they felt that the specialty society recommendation was too high and suggested the Harvard value for this procedure which is 1.06.</p>	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93312	Echo exam of heart	1.57	2.39	In their comment letter to HCFA, the specialty society noted that while many of the echocardiography procedures in the Medicare Fee Schedule have been reviewed, and in some instances revised, it is apparent that several echocardiography services, including 93312[Echocardiography, real-time with image documentation (2D) (with or without M-Mode recording), transesophageal; including probe placement, image acquisition, interpretation and report], continue to be undervalued in comparison to other services that require similar physician work effort.	The specialty society noted that the mental effort required to perform a transesophageal echo is considerable. As described in the previous discussion of 93307, the heart is constantly moving, increasing the possibility of misinterpretation which could lead to misdiagnosis. There is an added technical skill required by the physician to insert the probe into the esophagus and the stomach of a critically ill patient. This procedure is often performed in the emergency setting while the patient is under conscious sedation. In 1992, the ACC recommended an RVU for this service of 2.50. If the budget neutrality adjustments implemented since the inception of the MFS are applied to this value of 2.5, a 1995 value of 2.39 results. As a point of reference, Harvard Phase III data show a value (adjusted, per HCFA standards, to be on a scale equivalent to 1995 values) of 2.76 for CPT code 43235, the MPC code being used in this comparison. The Harvard Phase III value for TEE of 3.17, modified to be on the 1995 scale, reduces it to a value of 2.76 RVUs. The value is higher than both the existing value of 1.59 and the 2.39 value recommended by ACC. The specialty recommended an RVU of 2.39. The RUC agreed with the specialty society rationale, and recommended an increased RVU.	1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93320	Doppler echo exam, heart	0.38	0.38	In their comment letter to HCFA, the specialty society noted that while many of the echocardiography procedures in the Medicare Fee Schedule have been reviewed, and in some instances revised, it is apparent that several echocardiography services, including 93320[Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete], continue to be undervalued in comparison to other services that require similar physician work effort.	The ACC noted that this procedure is an add-on service to the 2D/mode echo [93307(0.78)] and is always reported with 93307. Doppler echo is a diagnostic ultrasonic technique. A spectral Doppler echo provides multiple functional measures including systolic and diastolic vascular performance. The RUC was informed that because of improved technology, generation of images that require more in depth analysis, has significantly changed the work of this procedure since 1993. Evidence was presented by the specialty society that during the 15 minute intra-service time of this procedure, the physician measures systolic and diastolic parameters and pulmonary pressures, while at the same time looking at images of flow velocities. Also during the intra-service time, the physician is calculating results by hand or with the assistance of a computer, and comparing this information to the data generated during 93307. The RUC recommended maintaining the current value of this procedure.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93503	Insert/place heart catheter	2.43	2.43	In their comments to HCFA, and their presentation SCCM noted that this procedure has been historically undervalued in relationship to the service that is being provided.	<p>CPT code 93503 describes the placement of the Swan-Ganz catheter. Although the actual catheterization procedure is the same as the right heart catheterization [93501(3.02)], right heart catheterization is performed under the controlled conditions of the cardiac catheterization lab. The work intensity of the 93503 is greater since it is usually performed in an emergency situation. The post service times of these procedures are also different as the right heart catheter stays in place for 1-2 hours, but the Swan-Ganz catheter is in place for five days. Because the Swan-Ganz catheter remains in place considerably longer, there is a significantly increased risk of sepsis, venous thrombosis, and pulmonary infarction.</p> <p>The RUC noted that Swan-Ganz catheters are also placed in the operating room which is usually a controlled atmosphere. They felt that although this code represents a higher work intensity for the critical care physician, this is not the case 100% of the time. The RUC did not feel that there was compelling evidence to increase the value of the code and recommended maintaining the current value of 2.43 for this procedure.</p>	2
93505	Biopsy of heart lining	4.56	4.38	In their comment letter to HCFA, the specialty society noted that they believe 93505 is slightly overvalued with an RVU of 4.56 relative to a left heart catheterization code 93510 with an RVU of 4.33. The specialty society also believes that the work RVU of 4.33 for a left heart catheterization be applied to 93505, as the physician work in both procedures is similar.	The RUC accepted the specialty society argument that 93505 is overvalued and recommends reducing the RVU of this procedure to 4.33 RVUs, which is the same RVU as the left heart catheterization CPT code 93510.	3
93527	Rt & Lt heart catheters	7.28	7.28	Although ACC submitted a public comment, after further review, the ACC believes that these codes are correctly valued and recommend no change.	The RUC agreed with the specialty society, and recommended maintaining the current value.	2
93529	Rt, Lt heart catheterization	4.80	4.80			2

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93539	Injection, cardiac cath	0.29	0.40	In their comments to HCFA, the ACC noted that although all of the injection codes (93539-93545) were valued 0.29 RVUs. HCFA recognized that CPT code 93540 does involve additional physician work and raised the RVU to 0.43 for this procedure. The ACC concurs with HCFA that all of the injection procedure codes do not involve the same amount of physician work, therefore each code should be placed on a scale of relative value units based on the actual work involved to maintain consistency within the RBRVS.	The RUC agreed with the specialty society rationale, and agreed to increase the RVU for this code. The RUC noted that this increased value for 93540 is due to the complexity associated with injecting into smaller vessels, and that this increase will maintain consistency within the family of codes.	1
93544	Injection for aortography	0.29	0.25	In their comments to HCFA, the ACC noted that although all of the injection codes (93539-93545) were valued 0.29 RVUs. HCFA recognized that CPT code 93540 does involve additional physician work and raised the RVU to 0.43 for this procedure. The ACC concurs with HCFA that all of the injection procedure codes do not involve the same amount of physician work, therefore each code should be placed on a scale of relative value units based on the actual work involved to maintain consistency within the RBRVS.	In this case, the amount of physician work involved in CPT code 93544[Injection procedure during cardiac catheterization; for aortography] is actually less than what the current RVU of this procedure reflects. Therefore, the specialty society recommended decreasing the RVU for this procedure from the current RVU of 0.29 to 0.23 RVUs. The RUC agreed with the specialty society rationale, and agreed to decrease the RVU for this code. 0.25	3
93545	Injection for coronary x-rays	0.29	0.40	In their comments to HCFA, the ACC noted that although all of the injection codes (93539-93545) were valued 0.29 RVUs. HCFA recognized that CPT code 93540 does involve additional physician work and raised the RVU to 0.43 for this procedure. The ACC concurs that all of the injection procedure codes do not involve the same amount of physician work, therefore each code should be placed on a scale of relative value units based on the actual work involved to maintain consistency within the RBRVS.	The RUC agreed with the specialty society rationale, and agreed to increase the RVU for this code. The RUC noted that this increased value for 93540 is due to the complexity associated with injecting into smaller vessels, and that this increase will maintain consistency within the family of codes.	1
93561	Cardiac output measurement	1.15	0.50	The CMDs commented that they felt the pre-, intra-, and post-service times of this code were inaccurate. They also noted that the methodology of this procedure has changed, with the procedure being performed by critical care nurses.	The RUC accepted the the CMD recommendation to decrease the RVUs for codes 93561 and 93562.	3
93562	Cardiac output measurement	0.37	0.16			3

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93641	Electrophysiology evaluation	5.93	5.93	In their public comment letter to HCFA the Mayo foundation requested that HCFA reconsider the RUC recommendation of 8.60 RVUs for this procedure to better reflect the physician work that is involved in providing this service. The letter notes that when compared to the additional work of testing the generator to code 93724[electronic analysis of an antitachycardia pacemaker system (4.94 RVUs), physicians indicate that the pulse generator testing involves more physician work. Physician work and risk to the patient are increased as life-threatening ventricular arrhythmias are induced to determine the initial settings.	<p>When the RUC reviewed this procedure in 1993 it recommended an RVU of 8.60. Although HCFA agreed that there was more physician work required to provide the service described by 93641 vs. 93640[Electrophysiologic evaluation of cardioverter-defibrillator leads (includes defibrillation threshold testing and sensing function) at time of initial implantation or replacement (3.52)] however, HCFA disagreed that the work was worth 5.00 more RVUs than the work of 93640. Instead, HCFA reasoned that the additional work of 93641 requires 1/2 hour of moderately high intensity intraservice work, which HCFA valued at 2.00 RVUs. Thus, HCFA established an initial value of 5.52 RVUs for this procedure.</p> <p>This code was presented to the RUC again in 1994. The RUC recommended to HCFA that the RVU of this procedure 5.93 which is the current value of this procedure. Since this procedure was recently reviewed by the RUC, the RUC recommends maintaining the current value of this procedure.</p>	2
93733	Telephone analysis, pacemaker	0.17	0.17	In the public comment letter submitted by Cardiac Datacorp-CardioCare which is a cardiac monitoring company that provides transtelephonic monitoring services, they noted that it is their belief that for dual chamber pacemakers, code 93733, the RVUs for physician work are disproportionately low and should be adjusted slightly upward. Specifically, they noted that for dual chamber pacemaker, more time is required for testing, interpretation and intervention relative to single chamber devices code 93736. They believe that this differential should be reflected in the work RVUs for telephone analysis, just as it is for clinical analysis. They conclude that the physician work RVUs for telephone analysis are currently undervalued by 20%.	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to support their comment, so the RUC recommends the current RVUs be maintained.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93875	Extracranial study	0.22	0.22	In their comments to HCFA the specialty society noted that they considered CPT code 93875[Noninvasive physiologic studies of extracranial arteries, complete bilateral study (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR noted that although 93875 is listed as a "complete bilateral" study, this service is equivalent to CPT code 93320(0.38), which is the performance of Doppler echo with pulse wave and/or continuous wave with spectral display. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2
93880	Extracranial study	0.60	0.60	In their comments to HCFA the specialty society noted that they considered CPT code 93880[Duplex scan of extracranial arteries; complete bilateral study] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR reported that this scan describes a "complete bilateral" study which is essentially equivalent in physician work to CPT codes 76700[Echography, abdominal, B-scan and/or real time with image documentation; complete (0.81)], 76770[Echography, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete(0.74)], and 93307[Echocardiography, real-time with image documentation (2D) with or without M-mode recording; complete(0.78)]. SCVIR also noted that scanning of the extracranial arteries also involves the same technology and instrumentation of 93307. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2
93882	Extracranial study	0.40	0.40	In their comments to HCFA the specialty society noted that they considered CPT code 93882[Duplex scan of extracranial arteries; unilateral or limited study] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR noted that the unilateral limited duplex study of the extracranial arteries involves similar work to the limited or follow-up 2-D echocardiographic evaluation 93308[Echocardiography, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study (0.53)] and/or limited ultrasound examination of the retroperitoneum or abdomen 76705[Echography, abdominal B-scan and/or real-time with image documentation; limited (eg, single organ, quadrant, follow-up (0.59)] and 76775[Echography, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; limited (0.58)]. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93922	Extremity study	0.25	0.25	In their comments to HCFA the specialty society noted that they considered CPT code 93922[Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR reported that although this service is bilateral, it involves only limited evaluation of a single arterial level, and as such is equivalent to limited studies of the pelvis 76857[Echography, pelvic (nonobstetric), B-scan and/or real-time with image documentation; limited or follow-up (eg, for follicles) (0.38)] and heart 93320[Doppler echocardiography, pulsed wave, and/or continuous wave with spectral display; complete (0.38)]. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2
93923	Extremity study	0.45	0.45	In their comments to HCFA the specialty society noted that they considered CPT code 93923[Noninvasive physiologic studies of upper or lower extremity arteries, multiple levels, or with provocative functional maneuvers complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR reported that this scan describes a "complete bilateral" study which is essentially equivalent in physician work to CPT codes 76700(0.81), 76770(0.74), and 93307(0.78). SCVIR also noted that scanning of the extracranial arteries also involves the same technology and instrumentation of 93307. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2
93924	Extremity study	0.50	0.50	In their comments to HCFA the specialty society noted that they considered CPT code 93924[Noninvasive physiologic studies of lower extremity arteries, at rest following treadmill stress testing, complete bilateral study] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR reported that this is a labor intensive service involving the evaluation of all lower extremity arteries before and after exercise testing. The recommended RVU for this procedure therefore, is related to the work involved in 93922 and 93923. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2
93925	Lower extremity study	0.58	0.58	In their comments to HCFA the specialty society noted that they considered CPT code 93925[Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR noted that this procedure is labor intensive and should be valued according to the above mentioned method for a "complete" study. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93926	Lower extremity study	0.39	0.39	In their comments to HCFA the specialty society noted that they considered CPT code 93926[Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR noted that the same rationale for the "limited" studies that were discussed above applies to this procedure as well. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2
93930	Upper extremity study	0.46	0.46	In their comments to HCFA the specialty society noted that they considered CPT code 93930[Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR noted that the same rationale for the "complete" studies that were discussed above applies to this procedure as well. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2
93931	Upper extremity study	0.31	0.31	In their comments to HCFA the specialty society noted that they considered CPT code 93931[Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR noted that the same rationale for the "limited" studies that were discussed above applies to this procedure as well. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2
93965	Extremity study	0.35	0.35	In their comments to HCFA the specialty society noted that they considered CPT code 93965[Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborhegography, impedance plethysmography)] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR noted that this procedure is equivalent to 93307(0.78) and should be given the same relative value. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2
93970	Extremity study	0.68	0.68	In their comments to HCFA the specialty society noted that they considered CPT code 93970[Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR noted that the same rationale for the "complete" studies that were discussed above applies to this procedure as well. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2
93971	Extremity study	0.45	0.45	In their comments to HCFA the specialty society noted that they considered CPT code 93971[Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study] undervalued relative to the amount of physician work involved in performing this procedure.	SCVIR noted that the same rationale for the "limited" studies that were discussed above applies to this procedure as well. The RUC did not accept the specialty society's arguments as compelling, and recommended maintaining the current value.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/Rationale	Key
93980	Penile vascular study	1.82	1.25	The CMDs believe that this procedure is similar to 93975[Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs; complete study] and the same rationale applies. A significant number of these procedures are done "incident to" the physician service by a technician. This study has less work and intensity than 99215[Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity], which typically requires 40 minutes of face to face physician time, and is similar to 45331[Sigmoidoscopy, flexible; with biopsy, single or multiple] and 99233[Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of high complexity].	The RUC accepted the CMD recommendation to decrease the RVU of this procedure.	3
93981	Penile vascular study	0.64	0.44	The CMDs noted that this decrease is the same percentage reduction as 93980. The reduction is necessary to maintain the established relationship of this procedure.	The RUC accepted the CMD recommendation to decrease the RVU of this procedure.	3

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SOCIETY OF CARDIOVASCULAR & INTERVENTIONAL RADIOLOGY

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September 25, 1995

Grant V. Rodkey, M.D.
AMA/Specialty Society RVS Update Process
American Medical Association
515 North State Street
Chicago, Illinois 60610

Dear Dr. Rodkey:

Re: SCVIR Comments on Percutaneous Revascularization Codes 35470 - 37206

On behalf of the Society of Cardiovascular and Interventional Radiology (SCVIR), a 2500 member organization composed of practicing vascular and interventional radiologists, we are pleased to include our comments on percutaneous vascular recanalization codes 35470 through 37206 which were commented upon by the Medicare carrier medical directors as part of the 5-Year Review Process. The carrier medical directors' comments were based upon a comparison between the codes for open angioplasty/atherectomy/stenting of vessels versus the percutaneous performance of the same procedures. In their comments they stated that the open and percutaneous procedures should be similarly paid but felt that the total work units paid for percutaneous revascularization procedures were greater because of the inclusion of arterial access as well as the inclusion of and supervision and interpretation codes.

During the initial phases of the RUC's work on the 5-Year Review process and public comments, the RUC recommended that the work values for percutaneous revascularization remain unchanged. We agree with this decision since we strongly believe that these percutaneous revascularization codes are appropriately valued having undergone the methodologic rigor of an extensive survey and scrutiny by the RUC. Nevertheless, we think that it is important for us to counter any misconceptions that might be present. These percutaneous revascularization procedures are an extremely important part of the practice of modern medicine. Changes in work values for these procedures and thus decreases in payments to physicians for providing these services would clearly negatively impact access to these services by Medicare beneficiaries.

The codes in question by the carrier medical directors include percutaneous angioplasty codes 35470 through 35476 which encompass percutaneous balloon angioplasty of the lower extremity vessels, renal, brachiocephalic arteries, and veins, as well as CPT codes 35490 through 35495 which describe percutaneous

atherectomy of the lower extremities, aorta, renal, and brachiocephalic arteries (there is no code for atherectomy of veins). Finally, 2 codes describe the percutaneous placement of stents in noncoronary vessels 37205 and 37206. The percutaneous codes are matched by CPT codes describing the open (surgical) performance of these same procedures.

Definition and Use of Open Revascularization Codes

For purposes of definition, it should be noted that open procedures are typically done by surgical arteriotomy (or venotomy) as an adjunct to performance of bypass procedures. The use of open angioplasty would occur for example in a situation in which a patient with an iliac artery stenosis proximal to an occluded superficial femoral artery required treatment of both lesions for adequate revascularization of the lower extremity. In this situation, the operating surgeon may choose to perform both procedures in the OR and angioplasty of the iliac artery would be done after exposure of the common femoral artery in order to improve inflow for subsequent femoral-popliteal bypass. A similar situation might be encountered in which an angioplasty is performed distal to a recently placed bypass graft in order to improve outflow after stenoses were visualized at the time of surgery. Another way in which open angioplasty is sometimes performed is as a pure substitute for percutaneous angioplasty, atherectomy, or stenting. In this situation a patient is brought to the operating room and a cut-down performed on the artery whereupon the artery is punctured with a needle (as in the percutaneous technique) and the procedure performed in that manner. In still other situations open angioplasty is simply performed in the operating room by direct percutaneous puncture of the artery in a totally analogous manner to that performed using percutaneous techniques. It is our contention that open vascular recanalization techniques are legitimate techniques when they are used at the time of surgery either in an adjunctive manner or in a situation in which percutaneous access is impossible or too dangerous. We believe that the utilization of open angioplasty when percutaneous techniques can and should be done is inappropriate since it typically involves more cost (operating room time) and subjects patients to the additional risk of general anesthesia. Thus, the use of the open percutaneous revascularization codes is necessarily limited to a relatively small group of patients with highly specific circumstances, usually those in which a surgical bypass procedure is being used.

Our rationale for retaining the current work values for these percutaneous recanalization codes is based on 3 separate issues: 1) History of the derivation of these values. 2) The equivalence of work with other percutaneous vascular interventions, specifically cardiac catheterization and coronary angioplasty. 3) Actual utilization of open angioplasty codes.

I. Construction and Valuation of Vascular (Coronary and Noncoronary) Access and Recanalization Codes

The current system of coding for peripheral vascular access, diagnostic arteriography, and percutaneous intervention dates to 1991 when a new group of codes for interventional radiology services was introduced into CPT and valued during the construction of the Medicare RBRVS. Further refinement of these codes by redefinition of angioplasty codes to include only balloon angioplasty and the introduction of new codes for atherectomy and stenting (with their subsequent valuation by the RUC) was completed in 1992 and 1993. At roughly the same time, coronary diagnostic and interventional services were also revised and revalued. The basis for the work values for angioplasty (introduced in 1992) and atherectomy and

stent (introduced in 1993) was careful survey of participating and practicing physicians including interventional radiologists, cardiologists, and vascular surgeons. Hsiao-based surveys were used to gather the data. Work values for these services were derived and presented to the RUC and accepted (with slight modifications by HCFA) as documented in the Federal Register, November 25, 1991 and November 25, 1992. One of the overriding concepts in valuation of all vascular recanalization codes was that the work involved in open and percutaneous procedures be identical.

II. Equivalence of Work with Other Percutaneous Vascular Interventions

It should be noted that for cases of noncoronary intervention, angioplasty is described separately from the arterial or venous access and the interpretation of the procedure. In the case of coronary angioplasty, a single CPT code is used to describe the entire activity including access to the vessel. This system has been carefully constructed to yield appropriate values for the physician work involved in these important therapeutic services and permits physicians to very accurately describe their activity. This coding system yields valid and reproducible comparisons between services, as we will illustrate. Below, we note 5 scenarios for percutaneous intervention in the coronary, renal, and lower extremity arteries with their associated work values.

Scenario 1

Diagnostic aortography and runoff arteriography combined with iliac angioplasty.

<u>CPT</u>	<u>Description</u>	<u>RVW</u>
36200	Aortic Cath Intro	1.51 (50 Percent Reduction)
75630	Aortogram and Runoff S&I	1.31
35473	Iliac Angioplasty	6.04
75962	Supervision and Interpretation of Iliac Angioplasty	0.54
	Total RVW	9.40

Scenario 2

Percutaneous iliac angioplasty alone.

<u>CPT</u>	<u>Description</u>	<u>RVW</u>
35473	Iliac Angioplasty	6.04
75962	Supervision and Interpretation of Iliac Angioplasty	0.54
36200	Aortic Catheterization	1.51 (50 Percent Reduction)
	Total RVW	8.09

Scenario 3

Left heart catheterization with coronary angioplasty.

<u>CPT</u>	<u>Description</u>	<u>RVW</u>
93510	Left Heart Catheterization	2.17 (50 Percent Reduction)
93543	Injection procedure for ventriculography	0.29
93545	Injection procedure for coronary arteriography	0.29
93555	Imaging supervision and Interpretation for Ventriculography	0.81
93556	Imaging Supervision and Interpretation for Coronary Arteriography	0.81
92982	PTCA Single Vessel	10.98
	Total RVW	15.35

Scenario 4

PTCA single vessel (CPT 92982), RVW 10.98.

Scenario 5

Femoralpopliteal angioplasty alone.

<u>CPT</u>	<u>Description</u>	<u>RVW</u>
35474	Femoralpopliteal Angioplasty	7.35
36246	Arterial Access	2.64 (50 Percent Reduction)
75962	Supervision and Interpretation for Angioplasty	0.54
	Total RVW	10.53

As the above illustrations show, there is a clear ranking of these various services using the current conventions. In these examples, the procedures ranked from least to most work are iliac angioplasty alone, iliac angioplasty with diagnostic arteriography of the aorta and lower extremities, femoral popliteal angioplasty alone (including access), coronary angioplasty of a single vessel without a diagnostic study, and full left heart catheterization with coronary angioplasty performed at the same sitting.

III. Actual Utilization of Open Codes

Where then does an open angioplasty fit in this coding scheme? The carrier medical directors contended that because open angioplasty/atherectomy/stenting is coded by itself and without arterial access, payment for open services is less, thereby violating the convention that open and percutaneous procedures should be equivalent. We believe that the reality of clinical practice and appropriate use of these codes leads to the conclusion that open (and percutaneous) revascularizations are properly valued. We make this statement for two reasons. First, examination of the clinical practice of open revascularization by evaluation of 1992 Medicare claims data shows that open revascularization procedures are often accompanied by other surgical codes. For open iliac and femoral-popliteal artery angioplasty, 65 to 75 percent of claims included another service (other than an E&M service) with the most common services being bypass grafts, thromboendarterectomy, other open angioplasties, or vascular injection procedures. For example, 61 percent of open iliac artery angioplasties are billed with a bypass graft, embolectomy, endarterectomy, exploratory, or repair procedure. Detailed enumeration of the codes billed with open femoral-popliteal and iliac angioplasty can be found in Tables 1 and 2. Second, the realities of appropriate clinical practice dictate that open revascularization codes are only appropriate when accompanied by another surgical procedure such as bypass graft or thromboendarterectomy or embolectomy. In these situations, open revascularization codes are used as an adjunct to the primary surgical bypass procedure or operation and, therefore, are properly valued. If the only procedure which is to be performed is a balloon angioplasty, stent or atherectomy, we strongly believe that it is inappropriate for a patient to be brought to the operating room and have these procedures performed in an open manner when percutaneous techniques accomplish the same result with less morbidity due to general anesthesia and less cost due to performance in a nonoperating room environment.

In summary then, we contend that percutaneous revascularization codes 35470 through 37206 are indeed properly valued when the history of their introduction and subsequent evaluation is examined. These codes also are properly valued in relationship to percutaneous coronary revascularization codes when they are either performed as separate procedures or combined with diagnostic arteriography. Finally, examination of the actual utilization of the codes shows that open revascularization codes are indeed properly billed with other surgical procedures in the majority of cases.

We appreciate the opportunity to comment on this important matter. If you have any questions, do not hesitate to contact us.

Sincerely yours,



Robert L. Vogelzang, M.D.

RLV:dw

TABLE 1

Codes Billed on Same Day as Femoral-Popliteal Open Angioplasty (Code 35456)
1992 Medicare Standard Analytical File -- Physician/Supplier Part B¹

Open angioplasty billed with:		Percent of Open Angioplasties Billed with Code in Specified Range ^{2,3}	Specialty Most Likely to Bill Code in Specified Range with an Open Angioplasty
Description	Code Range		
No other code		31%	Thoracic surgery Cardiovascular disease General surgery Vascular surgery
No other code except an E&M code	99201-99499	4%	Cardiovascular disease
Arterial embolectomy or thrombectomy / venous thrombectomy	34001-34490	8%	Thoracic surgery General surgery
Direct repair of aneurysm / graft insertion for aneurysm	35001- 35162	4%	Thoracic surgery General surgery
Repair arteriovenous fistula / repair blood vessel	35180-35286	2%	Thoracic surgery
Thromboendarterectomy	35301-35381	10%	Thoracic surgery General surgery
Open transluminal angioplasty (excluding femoral-popliteal)	35450-35460	9%	Thoracic surgery General surgery
Percutaneous transluminal angioplasty	35470-35476	3%	General surgery Cardiovascular disease
Bypass graft / in-situ vein bypass	35501-35681	13%	General surgery

continued

¹ Based on sample of 179 femoral-popliteal angioplasties as this is a 5 percent sample file of the Medicare Beneficiary File.

² Defined as those codes with same "first expense date" on the Medicare 1992 Physician/Supplier Beneficiary File.

³ As an open angioplasty is often billed with more than one code, these percentages do not sum to 100% and should not be added across codes.

TABLE 1

Codes Billed on Same Day as Femoral-Popliteal Open Angioplasty (Code 35456)
1992 Medicare Standard Analytical File -- Physician/Supplier Part B¹

Open angioplasty billed with:		Percent of Open Angioplasties Billed with Code in Specified Range ^{2,3}	Specialty Most Likely to Bill Code in Specified Range with an Open Angioplasty
Description	Code Range		
Exploration	35701-35910	4%	Thoracic surgery General surgery Clinic or other group practice
Vascular injection procedures	36000-36680	22%	General surgery
Transcatheter therapy and biopsy	37200-37204	2%	Thoracic surgery General surgery
Ligation and other procedures	37565-37799	2%	No one specialty
Radiologic S&I	70010-75989	19%	General surgery Radiology
Fluoroscopy	76000-76003	2%	Thoracic surgery
Cardiac catheterization	93501-93562	0%	N/A
E&M service	99201-99499	9%	Thoracic surgery Cardiovascular disease General surgery
Other	varies ⁴	9%	Thoracic surgery General surgery

¹ Based on sample of 179 femoral-popliteal angioplasties as this is a 5 percent sample file of the Medicare Beneficiary File.

² Defined as those codes with same "first expense date" on the Medicare 1992 Physician/Supplier Beneficiary File.

³ As an open angioplasty is often billed with more than one code, these percentages do not sum to 100% and should not be added across codes.

⁴ For code 35456 this category includes the following codes each of which had a frequency of only 1: 11043, 11044, 27601, 27602, 28805, 28820, 35483, 49550, 76953, 90220, 90605, 90653, 90783, 93921, and A9270.

TABLE 2

**Codes Billed on Same Day as an Iliac Open Angioplasty (Code 35454)
1992 Medicare Standard Analytical File -- Physician/Supplier Part B¹**

Open angioplasty billed with:		Percent of Open Angioplasties Billed with Code in Specified Range ^{2,3}	Specialty Most Likely to Bill Code in Specified Range with an Open Angioplasty
Description	Code Range		
No other code		23%	General surgery
No other code except an E&M code	99201-99499	1%	No one specialty
Arterial embolectomy or thrombectomy / venous thrombectomy	34001-34490	1%	No one specialty
Direct repair of aneurysm / graft insertion for aneurysm	35001- 35162	0%	N/A
Repair arteriovenous fistula / repair blood vessel	35180-35286	3%	No one specialty
Thromboendarterectomy	35301-35381	15%	Thoracic surgery General surgery
Open transluminal angioplasty (excluding iliac)	35450-35460	11%	General surgery
Percutaneous transluminal angioplasty	35470-35476	2%	No one specialty
Bypass graft / in-situ vein bypass	35501-35681	38%	General surgery Thoracic surgery
Exploration	35701-35910	1%	No one specialty
Vascular injection procedures	36000-36680	24%	General surgery Radiology
Transcatheter therapy and biopsy	37200-37204	0%	N/A

continued

¹ Based on sample of 97 iliac angioplasties as this is a 5 percent sample file of the Medicare Beneficiary File.

² Defined as those codes with same "first expense date" on the Medicare 1992 Physician/Supplier Beneficiary File.

³ As an open angioplasty is often billed with more than one code, these percentages do not sum to 100% and should not be added across codes.

TABLE 2

Codes Billed on Same Day as an Iliac Open Angioplasty (Code 35454)
1992 Medicare Standard Analytical File -- Physician/Supplier Part B¹

Open angioplasty billed with:		Percent of Open Angioplasties Billed with Code in Specified Range ^{2,3}	Specialty Most Likely to Bill Code in Specified Range with an Open Angioplasty
Description	Code Range		
Ligation and other procedures	37565-37799	3%	Thoracic surgery
Radiologic S&I	70010-75989	22%	Radiology Thoracic surgery Cardiovascular disease
Fluoroscopy	76000-76003	1%	No one specialty
Cardiac catheterization	93501-93562	3%	Cardiovascular disease
E&M service	99201-99499	6%	Radiology General surgery Cardiovascular disease
Other	varies ⁴	9%	Radiology

¹ Based on sample of 97 iliac angioplasties as this is a 5 percent sample file of the Medicare Beneficiary File.

² Defined as those codes with same "first expense date" on the Medicare 1992 Physician/Supplier Beneficiary File.

³ As an open angioplasty is often billed with more than one code, these percentages do not sum to 100% and should not be added across codes.

⁴ For code 35454 this category includes the following codes each of which had a frequency of only 1: 01918, 11042, 28810, 31631, 90605, 90783, 92982, 93307, A9270, and Z9998.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 93010+93000 (Global) Global Period: XXX Current RVW: 0.17 Recommended RVW: 0.17

CPT Descriptor: Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only.

Source and Summary of Comment to HCFA on this service: CMD's identified this procedure as overvalued, based on two articles stating a machine can appropriately read an ECG. In 1993 the ACC and the American Society of Internal Medicine successfully refuted this assertion based on clinical evidence, resulting in the repeal of the ECG law.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 69 year old man is seen in the office for evaluation of chest tightness and palpitations. A 12-lead electrocardiographic (ECG) tracing is obtained by technical personnel along with clinical and drug therapy data. The tracing is reviewed by the physician, appropriate measurements are made (including axis, intervals, and voltages), an overall interpretation is made. The tracing is compared to previous ECG tracings, when available. Potential etiologies for any electrocardiographic findings observed, such as myocardial infarction, hypokalemia or digoxin toxicity, etc. are proposed. A report is prepared, signed and transmitted to the patient's medical record.

Description of Pre-Service Work: The rationale for the ECG request is reviewed along with any pertinent patient history.

Description of Intra-Service Work: The tracing is reviewed by the physician, appropriate measurements are made (including axis, intervals, and voltages), an overall interpretation is made. The tracing is compared to previous ECG tracings, when available. Potential etiologies for any electrocardiographic findings observed, such as myocardial infarction, hypokalemia or digoxin toxicity, etc. are proposed.

Description of Post-Service Work: A report is prepared, signed and transmitted to the patient's medical record.

SURVEY DATA:

Specialty: American College of Cardiology & American Society of Internal Medicine

Sample Size: 213 Response Rate (%): 64 (30%) Median RVW: .18

25th Percentile RVW: .15 75th Percentile RVW: .22 Low: .07 High: 1.51

Median Pre-Service Time*: 1.0 Median Intra-Service Time*: 2.0 min

25th Percentile Intra-Svc Time*: 2.0 75th Percentile Intra-Svc Time*: 4.0 Low: 0 High: 10.0

* Time is reported in minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>1.0 min</u>	
ICU:	<u>N/A</u>	<u>N/A</u>
Other Hospital:	<u>N/A</u>	<u>N/A</u>
Office:	<u>N/A</u>	<u>N/A</u>

Specialty: American College of PhysiciansSample Size: 240 Response Rate (%): 32 (13%) Median RVW: 0.2025th Percentile RVW: 0.177 75th Percentile RVW: 0.263 Low: 0.11 High: 1.0Median Pre-Service Time*: 0 Median Intra-Service Time*: 5.0 min25th Percentile Intra-Svc Time*: 3.0 75th Percentile Intra-Svc Time*: 5.0 Low: 1.0 High: 15.0

* Time is reported in minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>2.0 min</u>	
ICU:	<u>N/A</u>	<u>N/A</u>
Other Hospital:	<u>N/A</u>	<u>N/A</u>
Office:	<u>N/A</u>	<u>N/A</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	71020	Chest x-ray, two views	0.22
2)	99212	Office visit, est, level 2	0.38
	93224	ECG monitor/report, 24 hours	0.52
4)	99213	Office visit, est, level 3	0.55

[ACP KEY REFERENCE SERVICE(S)]

5)	93000	12-lead ECG, complete	0.17
6)	94010	Spirometry	0.17
7)	71010	Chest x-ray, single view	0.18

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The interpretation of a standard 12-lead ECG is equivalent to that of interpreting a chest x-ray (71010). Both of these services are valuable diagnostic tools used for a wide range of patient conditions.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The Medicare carrier medical directors (CMDs) base their assertion that this is an overvalued procedure on the statement that ECGs are typically interpreted by computer. Although most hospitals are equipped with this technology, physicians offices typically are not. Furthermore, even when interpreted by a computer, the ECGs must be over read by a physician. Current computer applications frequently misread normal ECGs as abnormal and arrhythmias are problematic for the computers as well. In patients being followed with serial ECGs, clinical information is important to the correct interpretation and this information cannot be assimilated by a computer. Survey respondents indicated this service requires a mental effort and judgement at level 3, technical skill and physical effort at level 2, and psychological stress at level 2-3. Overall, the work, technology, typical patient and usual site of service have not changed in the last five years.

We strongly recommend therefore, that the current value of 0.17 for this vital diagnostic service remain unchanged. Our survey results overwhelmingly support this recommendation.

CMD Comments

06-Jul-95

Code: 93000

1995 RVUs: 0.17

Recommended RVUs: 0.05

Ratio: -0.71

Long Descriptor: Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

Reference Set (y/n): N Global Period: XXX Frequency: 8,636,175 Impact: -1036341

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
93000			
	99213 OFFICE/OUTPATIENT VISIT, EST	0.55	XXX
	99243 OFFICE CONSULTATION	1.47	XXX

CMD Comment:

The interpretation of the great majority of electrocardiograms is straightforward and involves relatively few parameters in comparison to history and physical examination. The risk involved is no different than the risk of the E & M service prompting the order. The time involved in ECG interpretation has been directly measured and reported in the literature. The time of interpretation (intraservice time), taken from a sample selected to be far more difficult than typically encountered (90% abnormal), averaged less than one minute (Medical Decision Making, 1992; 12:331). Physicians have been observed to read 30 to 40 electrocardiograms in one hour, with total time (interpretation and report), averaging 97 seconds (American Journal of Cardiology, 1978; 41:175-183). The recommended value equates 99213 (intraservice time 15 minutes, total time 21 minutes) with eleven ECGs and 99243 (intraservice time 40 minutes, total time 56 minutes) with 30 ECGs.

Societies Wishing to Survey: ACC, ACP, ASIM

Societies Wishing to Comment: AAFP, AAPA

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
93000	50.4	11.8	9.8	56.4	5.2	0.1	0.4	9.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
93000	673555	8795464	261.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
93000	0	0.3	0.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
93000		
	cardiovascular disease	31.3
	general/family practice	16.7
	group practices	3

CMD Comments

06-Jul-95

internal medicine	40.9
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Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
93000		
250	1.8	DIABETES MELLITUS
272	2.1	DISORDERS OF LIPOID METABOLISM
401	5.9	ESSENTIAL HYPERTENSION
413	1.7	ANGINA PECTORIS
414	5.6	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	4.5	CARDIAC DYSRHYTHMIAS
428	1.7	HEART FAILURE
786	4.2	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
93000							
CMD		XXX	XXX	0.25	0.17	0.68	0.17

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
93000								
CMD	0.17	0.17	0.68	1.00	1.00	1.00	0.05	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ftime	Notett	Imppt
93000								
CMD	XXX	0.25	t	.		8	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
93000									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
93000									

CMD Comments

06-Jul-95

CMD	0.05	0.17	im	n	0.031
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CMD Comments

06-Jul-95

Code: 93010 1995 RVUs: 0.17 Recommended RVUs: 0.05 Ratio: -0.71

Long Descriptor: Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

Reference Set (y/n): Y Global Period: XXX Frequency: 16,114,378 Impact: -1933725.36

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
93010			
	99213 OFFICE/OUTPATIENT VISIT, EST	0.55	XXX
	99243 OFFICE CONSULTATION	1.47	XXX

CMD Comment:

The interpretation of the great majority of electrocardiograms is straightforward and involves relatively few parameters in comparison to history and physical examination. The risk involved is no different than the risk of the E & M service prompting the order. The time involved in ECG interpretation has been directly measured and reported in the literature. The time of interpretation (intraservice time), taken from a sample selected to be far more difficult than typically encountered (90% abnormal), averaged less than one minute (Medical Decision Making, 1992; 12:331). Physicians have been observed to read 30 to 40 electrocardiograms in one hour, with total time (interpretation and report), averaging 97 seconds (American Journal of Cardiology, 1978; 41:175-183). The recommended value equates 99213 (intraservice time 15 minutes, total time 21 minutes) with eleven ECGs and 99243 (intraservice time 40 minutes, total time 56 minutes) with 30 ECGs.

Societies Wishing to Survey: ACC, ACP, ASIM

Societies Wishing to Comment: AAFP, ACEP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
93010	53.9	16.3	13	55.3	7.9	0.6	2	12.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
93010	50297	17617014	1771.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
93010	65.8	68.6	1.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
93010		
	cardiovascular disease	53.7
	emergency medicine	2.6
	general/family practice	3.3

CMD Comments

06-Jul-95

group practices	9.1
internal medicine	27.8

Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
93010		
401	1.4	ESSENTIAL HYPERTENSION
410	1.5	ACUTE MYOCARDIAL INFARCTION
411	1.5	OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE
414	2.6	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	3.8	CARDIAC DYSRHYTHMIAS
428	2.8	HEART FAILURE
780	1.3	GENERAL SYMPTOMS
786	4.5	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
93010							
CMD		XXX	XXX	0.17	0.17	1.00	0.17

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
93010								
CMD	0.17	0.17	1.00	1.00	1.00	1.00	0.05	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
93010								
CMD	XXX	0.17	t	.		5	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
93010									
CMD									

Harvard Data:

CMD Comments

06-Jul-95

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfawk95	Sp	Phase	Twput	lwput
93010									
CMD				0.05	0.17	xx	n	0.034	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 93307 Global Period: XXX Current RVW: 0.78 Recommended RVW: 1.48

CPT Descriptor: Echocardiography, real-time with image documentation (2D) with or without M-mode recording, complete

Source and Summary of Comment to HCFA on this service: American College of Cardiology and the American Society of Echocardiography reviewed these services and determined that they remain undervalued compared to other services within the Medicare Fee Schedule which require similar physician work effort.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year old man with chest pressure and shortness of breath is admitted with cardiomegaly and pulmonary congestion on chest and ECG changes of left bundle branch block. The physician reviews existing information (e.g. request for a consult) and relevant clinical data to clarify the indications for the procedure and determine the clinical questions that needed to be answered. A sequence of tomographic images from multiple views is obtained and recorded: the physician may verify the suitability of the images prior to the completion of the study and obtain additional views if necessary. Video-taped or digitally recorded views of the heart are reviewed, the structure and dynamics of the heart chambers, valves, and great vessels are analyzed and measured, and a complete interpretation is developed. Evaluations of quantitative, anatomic and functional measures such as left ventricular size, wall thickness, ejection fraction, regional wall motion, and left ventricular mass, atrial and aortic root dimensions, etc. are made. Multiple sets of tomographic views are evaluated and compared to previous studies for quantitative and qualitative changes. A report is dictated and the findings may be reviewed in detail with the referring physician.

Description of Pre-Service Work: The physician reviews existing information (e.g. request for a consult) and relevant clinical data to clarify the indications for the procedure and determine the clinical questions that needed to be answered.

Description of Intra-Service Work: A sequence of tomographic images from multiple views is obtained and recorded; the physician may verify the suitability of the images prior to the completion of the study and obtain additional views if necessary. Video-taped or digitally recorded views of the heart are reviewed, the structure and dynamics of the heart chambers, valves, and great vessels are analyzed and measured, and a complete interpretation is developed. Evaluations of quantitative, anatomic and functional measures such as left ventricular size, wall thickness, ejection fraction, regional wall motion, and left ventricular mass, atrial and aortic root dimensions, etc. are made. Multiple sets of tomographic views are evaluated and compared to previous studies for quantitative and qualitative changes.

Description of Post-Service Work: A report is dictated and the findings may be reviewed in detail with the referring physician.

SURVEY DATA:Specialty: American College of Cardiology and the American Society of EchocardiographySample Size: 101 Response Rate (%): 32 (31%) Median RVW: 1.525th Percentile RVW: 1.01 75th Percentile RVW: 1.86 Low: 0.60 High: 3.0Median Pre-Service Time*: 5.0 Median Intra-Service Time*: 18.025th Percentile Intra-Svc Time*: 15.0 75th Percentile Intra-Svc Time*: 20.0 Low: 5.0 High: 40.0

* Time is reported in minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5.0</u>	
ICU:	<u>N/A</u>	<u>N/A</u>
Other Hospital:	<u>N/A</u>	<u>N/A</u>
Office:	<u>N/A</u>	<u>N/A</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	78465	Myocardial perfusion imaging, SPECT, multiple studies	1.48
2)	99215	Office visit, est, level 5	1.51
3)	93015	Exercise ECG, supervision, I&R	0.75
4)	99214	Office visit, est, level 4	0.94

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Two-D, M-mode echocardiography and SPECT thallium imaging (78465) are important and somewhat similar cardiovascular diagnostic tools. Each service provides different information; however, the work effort involved in both services is comparable. There is considerable mental effort involved in the interpretation of SPECT thallium images that require skill in nuclear physics and cardiovascular medicine. The physician must know coronary anatomy, physiology of coronary circulation, anatomic variation, left ventricular function, kinetics of radiotracer, attenuation, scatter, partial volume effect, and cardiac and extracardiac causes of artifacts. The interpreter should be aware of the relationship between coronary flow and tracer concentration in relation to the type of tracer and the type of stress test used. The recognition of soft tissue attenuation artifacts is necessary to maintain a high specificity.

The mental effort in interpreting an echocardiogram is considerable. The physician must evaluate a large number of cardiac structures and their dynamics, keeping in mind the wide range of both congenital and acquired diseases that can affect the heart. These judgements must be made despite the fact that the heart is constantly moving, increasing the possibility of a misinterpretation. Ultrasonic artifacts must be recognized for an appropriate evaluation to be

completed. Mental acuity under pressure is required when study interpretation is done in the setting of acute patient care situations. The quality of the examiner directly affects the data derived for final interpretation. Considerable technical skill is required for both the performance and the interpretation of the study, as many structures must be located, properly identified and assessed for pathological processes.

Note: Mental effort and judgement were surveyed at level 4, technical skill and physical effort at level 3-4, psychological stress at level 2. About half of the respondents indicated the work of this code has changed in the last five years because the patients requiring this service are increasingly complex. All agree that the vignette describes their typical patient.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The mental effort in interpreting an echocardiogram is considerable. The physician must evaluate a large number of cardiac structures and their dynamics, keeping in mind the wide range of both congenital and acquired diseases that can affect the heart. These judgements must be made despite the fact that the heart is constantly moving, increasing the possibility of a misinterpretation. Ultrasonic artifacts must be recognized for an appropriate evaluation to be completed. Mental acuity under pressure is required when study interpretation is done in the setting of acute patient care situations. The quality of the examiner directly affects the data derived for final interpretation. Considerable technical skill is required for both the performance and the interpretation of the study, as many structures must be located, properly identified and assessed for pathological processes.

Echocardiography is not only applied in the clinically stable patient but also at the bedside of critically ill patients and in the emergency setting. The information derived from the study is used in the development of critical management decisions. The risk of misdiagnosis, which can lead to potentially fatal events, in both emergent and non-emergent settings, adds an additional stress factor.

Based on this information, the College recommends that a concensus value of 1.48 be adopted, given the median survey value of 1.50 and the similarity of work effort for this echocardiography service and that of SPECT thallium.

Public Comments

06-Jul-95

Code: 93307

1995 RVUs: 0.78

Recommended RVUs: 1.67

Ratio:

Long Descriptor: Echocardiography, real-time with image documentation (2D) with or without M-mode recording, complete

Reference Set (y/n): Y Global Period: XXX Frequency: 3,230,057 Impact: 2874751

Source: 7 Year: 93 Public Comment Letter: 288

Reference Services:

CMD Comment:

--

Societies Wishing to Survey: ACC, ACP

Societies Wishing to Comment: ACR, AOA, ASIM, SCVIR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
93307	52.7	14.1	13.2	56	7.1	0.6	1.6	10.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
93307	3191922	3596686	6.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
93307	54.4	52	-1.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
93307	cardiovascular disease	71.2
	group practices	5
	internal medicine	16.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
93307	401	1.7	ESSENTIAL HYPERTENSION
	414	3.1	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
	424	6.9	OTHER DISEASES OF ENDOCARDIUM

AMA/Specialty Society RVS Update Process

Public Comments

06-Jul-95

427	3.5	CARDIAC DYSRHYTHMIAS
428	3.8	HEART FAILURE
429	1.6	ILL-DEFINED DESCRIPTIONS AND COMPLICATIONS OF HEART DISEASE
785	1.7	SYMPTOMS INVOLVING CARDIOVASCULAR SYSTEM
786	3.7	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
93307							
ACC		XXX	XXX	1.06	0.78	0.74	0.39

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
93307								
ACC	0.78	0.78	0.37	2.00	1.00	1.00	1.67	288

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
93307								
ACC	XXX	1.06	t	.		25	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
93307									
ACC									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
93307									
ACC				1.67	0.78	ca	3	0.042	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 93312 Global Period: XXX Current RVW: 1.57 Recommended RVW: 2.39

CPT Descriptor: Echocardiography, real-time with image documentation (2D) with or without M-mode recording, transesophageal, complete

Source and Summary of Comment to HCFA on this service: American College of Cardiology and the American Society of Echocardiography reviewed these services and determined that they remain undervalued compared to other services within the Medicare Fee Schedule which require similar physician work effort.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year old woman with a prosthetic mitral valve has developed new onset of fever, chills and tachycardia, but no change in murmur and no apparent mass (vegetation) by transthoracic echocardiography. She has been taking antibiotics for a "bronchitis" and six sets of blood cultures are negative. The physician reviews the request for the consult, as well as previous clinical data and lab results, to clarify the indications for the procedure and determine the clinical questions for which the referring physician is seeking an answer. A preliminary evaluation of the patient, including history and physical examination is performed to determine the relative risks and benefits. The patient is prepared for upper endoscopy, including management of the airway. The oral pharynx is anesthetized. Intravenous access is established and the patient is given conscious sedation, anxiolytics and/or prophylactic antibiotic treatment as necessary. Vital signs such as blood pressure, pulse rate and arterial oxygen saturation are monitored. The physician inserts the probe into the esophagus and stomach, and the structures of the heart are identified in multiple views. Each of the valves and chambers is visualized, and the great vessels are also imaged. Considerable physician effort is required to obtain proper images of the structure and function of the heart and great vessels, from multiple positions and orientations. In each view of the heart, recorded on video tape or disk, a detailed interpretation of the anatomy, dynamics and function is made. For example, mobility, thickness and excursion of a valve's leaflets, possible regurgitation, heart function and presence of intracardiac shunts are noted throughout the heart cycle from each view. After the procedure the patient is monitored (BP, heart rate, respirations, arterial oxygen saturation) to ensure complete recovery from the sedation.

Description of Pre-Service Work: The physician reviews the request for the consult, as well as previous clinical data and lab results, to clarify the indications for the procedure and determine the clinical questions for which the referring physician is seeking an answer. A preliminary evaluation of the patient, including history and physical examination is performed to determine the relative risks and benefits. The patient is prepared for upper endoscopy, including management of the airway.

Description of Intra-Service Work: The oral pharynx is anesthetized. Intravenous access is established and the patient is given conscious sedation, anxiolytics and/or prophylactic antibiotic treatment as necessary. Vital signs such as blood pressure, pulse rate and arterial oxygen saturation are monitored. The physician inserts the probe into the esophagus and stomach, and the structures of the heart are identified in multiple views. Each of the valves and chambers is visualized, and the great vessels are also imaged. Considerable physician effort is required to obtain proper images of the structures and function of the heart and great vessels, from multiple positions and orientations. In each view of the heart, recorded on video tape or disk, a detailed interpretation of the anatomy, dynamics and function is made. For example, mobility, thickness and excursion of a valve's leaflets, possible regurgitation, heart function and presence of intracardiac shunts are noted throughout the heart cycle from each view.

Description of Post-Service Work: After the procedure the patient is monitored (BP, heart rate, respirations, arterial oxygen saturation) to ensure complete recovery from the sedation.

SURVEY DATA:Specialty: American College of CardiologySample Size: 101 Response Rate (%): 32 (31%) Median RVW: 3.025th Percentile RVW: 2.43 75th Percentile RVW: 4.25 Low: 1.5 High: 25.0* *Median Pre-Service Time*: 15.0 Median Intra-Service Time*: 13.025th Percentile Intra-Svc Time*: 21.25 75th Percentile Intra-Svc Time*: 43.75 Low: 5.0 High: 80.0

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>15.0</u>	
ICU:	<u>N/A</u>	<u>N/A</u>
Other Hospital:	<u>N/A</u>	<u>N/A</u>
Office:	<u>N/A</u>	<u>N/A</u>

* Time is reported in minutes

** Dropping out this high outlier does not change the median value

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	43235	Upper gastrointestinal endoscopy (diagnostic)	2.39
2)	33010	Drainage of heart sac	2.24
3)	92950	CPR	3.80
4)	93224	ECG monitor/report, 24 hours	0.52

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Both transesophageal echocardiography (TEE) and diagnostic upper GI endoscopy use endoscopic imaging methods to evaluate structural and functional abnormalities - the former in the cardiovascular system and the latter in the upper GI tract. One factor which increases the physician work effort for TEE is that the esophageal probe must be blindly placed. This increases the risk of airway obstruction in patients undergoing TEE. Physician work and complexity are comparable for pre-, intra-, and post-service components. Although the upper GI evaluation involves several organs (the esophagus, stomach and upper small bowel), the TEE evaluation involves a complex and constantly moving organ with multiple component structures (the heart).

The psychological stress and gravity of the decision making in TEE is significant. Decisions involving the need for and approach to cardiac valve surgery, the need for immediate surgery for dissecting aortic aneurysm, the need for long term anticoagulation to reduce the risk of stroke, and the length of treatment for endocarditis, are all common in daily practice with TEE. Additional psychological stress is related to informing the cardiovascular surgeon that the repair of a valve is inadequate and reestablishment of cardiopulmonary bypass (with its attendant increased risk of morbidity and mortality) is recommended.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The mental effort in performing and interpreting a transesophageal echocardiogram is considerable. The physician must keep in mind all cardiac diseases and disorders (both congenital and acquired). Further, the heart is constantly moving, increasing the possibility of misinterpretation and presence of artifacts which must be distinguished for an appropriate evaluation to be completed. Patients are often ill and may have a host of co-morbidities such as heart failure, cardiac trauma, rupture of major vessel, other organ system failure, hypotension, infection or recent stroke. In the operating room scenario, during and after cardiopulmonary bypass, assessment of valve dynamics and function is critical as blood pressure is returning to normal values.

There is an added technical skill required related to the insertion of the probe into the esophagus and stomach in a critically ill patient. The interpretation of the study is also demanding, as many structures must be located, properly identified, and assessed carefully for abnormalities. This includes the assimilation of the two dimensional images into a three dimension concept to assess flaws in the heart.

Transesophageal echocardiography is frequently applied in the emergency setting and the information derived from the study is used in the development of critical treatment protocols. The management of a patient with conscious sedation, as well as the passing of the endoscope blindly past the airway in critically ill patients, adds significantly to the stress. The risk of misdiagnosis, which could lead to patient death, in both emergent and non-emergent settings, adds an additional stress factor.

In summary, mental effort and judgement are estimated at level 4-5, technical skill and physical effort at level 4-5, psychological stress at level 4. The majority of respondents indicated the work of this code has changed in the last five years, although the familiarity with the technology is stable. Basically, the patients requiring this service are increasingly complex. All agree that the vignette describes their typical patient.

In 1992, the College recommended a RVU for this service of 2.5. If the budget neutrality adjustments implemented since the inception of the MFS are applied to this value of 2.5, a 1995 value of 2.39 results. As a point of reference, Harvard Phase III data show a value (adjusted, per HCFA standards, to be on a scale equivalent to 1995 values) of 2.76 for CPT code 43235, the MPC code being used in this comparison. HCFA lowered the Phase III value by 15 percent to 2.39. The Harvard Phase III value for TEE of 3.12, modified by the same corrections (including the reduction of 15 percent), reduces it to a value of 2.76 RVUs. This value is higher than both the existing value of 1.59 and the 2.39 value recommended by the College. **The College's survey results indicate a median value of 3.0 RVUs. We believe a consensus value of 2.39 should be adopted.**

Public Comments

06-Jul-95

Code: 93312

1995 RVUs: 1.57

Recommended RVUs: 2.39

Ratio:

Long Descriptor: Echocardiography, real time with image documentation (2D) (with or without M-Mode recording), transesophageal; including probe placement, image acquisition, interpretation and report

Reference Set (y/n): N Global Period: XXX Frequency: 68,268 Impact: 55980

Source: 4 Year: 94 Public Comment Letter: 288

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACC, ACP

Societies Wishing to Comment: ACR, AOA, ASIM, SCVIR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
93312	42.7	4.8	11.8	48.1	8.4	0.8	2.3	6.4

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
93312	59495	73564	11.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
93312	77.9	78.6	0.4

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
93312	anesthesiology	14.4
	cardiovascular disease	65.2
	group practices	6.6
	internal medicine	10.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
93312	394	1.4	DISEASES OF MITRAL VALVE
	396	1.3	DISEASES OF MITRAL AND AORTIC VALVES

AMA/Specialty Society RVS Update Process

Public Comments

06-Jul-95

414	4.1	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
424	9	OTHER DISEASES OF ENDOCARDIUM
427	2.9	CARDIAC DYSRHYTHMIAS
428	2.1	HEART FAILURE
436	1.2	ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR DISEASE
786	1.4	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
93312							
ACC		XXX	XXX	3.17	1.57	0.50	0.50

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
93312								
ACC	1.57	1.57	0.16	3.14	1.00	1.00	2.39	288

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
93312								
ACC	XXX	3.17	t			54	t	

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
93312									
ACC									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
93312									
ACC				2.39	1.57	ca	3	0.059	

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 93539 Global Period: XXX Current RVW: 0.29 Recommended RVW: 0.40

CPT Descriptor: Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (e.g., internal mammary), whether native or used for bypass

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old man or woman with previous saphenous vein strippings for varicose veins and coronary angiographic evaluation suggesting that bypass surgery is the treatment of choice.

This is an add-on procedure during a cardiac catheterization that entails selecting, exchanging, if necessary, and positioning the proper catheter in the arterial conduits used or to be used for bypass surgery and then positioning the patient and the X-ray properly. The physician must decide on the type and amount of contrast and injection method to best present the needed data in the particular patient's situation. The catheter may be connected to the mechanical injector but the injection is usually manual and administered by the cardiologist. The panning (movement) of the x-ray table during the injection and filming must be expertly performed to assure full visualization of the artery or conduit. The radiologic angle or angles must be expertly chosen to provide full visualization of the artery or conduit so that accurate anatomic decisions can be made. The force and duration of the manual injection must be expertly performed in order to assure complete opacification of the target artery or conduit with contrast (and without a "streaming" phenomenon mixture of blood and contrast). The conscious patient may experience a "hot flush" of varying intensity and be subject to potential serious cardiac arrhythmias and even fluid overload with possible heart failure and/or myocardial depression in addition to potential embolic phenomena during the injection or peri-injection. Air must be carefully eliminated from the catheter as air emboli pose a significant risk to the patient. An additional risk during this type of angiogram is extravascular extravasation of the contrast material which has the potential to produce arrhythmias, myocardial damage, even significant pericardial effusions which could lead to cardiac tamponade. Anxiety and allergic contrast reactions are often experienced and also must be coped with immediately and can produce an emergent situation. An immediate decision on the acceptability of the recorded angiogram must be made, and if not acceptable, a repeat angiogram must be considered. These arterial conduit angiograms range from 4 to 10 cc's in volume and because multiple injections are typically required, consideration regarding overload contrast can become a significant factor in a patient with renal impairment and necessitate close follow-up and extra therapy such as fluid loading and diuretics to counteract the problems.

Description of Pre-Service Work: N/A

Description of Intra-Service Work: See clinical vignette above

Description of Post-Service Work: N/A

SURVEY DATA:Specialty: American College of CardiologySample Size: 114 Response Rate (%): 53 (47%) Median RVW: 0.4025th Percentile RVW: 0.30 75th Percentile RVW: 0.44 Low: 0.23 High: 0.55Median Pre-Service Time*: 0 Median Intra-Service Time: 10.025th Percentile Intra-Svc Time*: 7.0 75th Percentile Intra-Svc Time: 15.0 Low: 5.0 High: 23.0

* Time is reported in minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>N/A</u>	
ICU:	<u>N/A</u>	<u>N/A</u>
Other Hospital:	<u>N/A</u>	<u>N/A</u>
Office:	<u>N/A</u>	<u>N/A</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	93540	Injection procedure during cardiac cath for selective opacification of aortacoronary venous bypass grafts, one or more coronary arteries	0.43
2)	93543	Injection procedure during cardiac cath for selective left ventricular or left atrial angiography	0.29

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The physician work involved in the series of cardiac angiography injection codes varies depending on the nature of the structures being filmed and the difficulty in accessing these. This surveyed service, injection for the selective opacification of arterial conduits, requires more work than most of the other services in the series.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Based on the comparative note above, the ACC recommends the median physician RVU of 0.40 be adopted.

Public Comments

06-Jul-95

Code: 93539 1995 RVUs: 0.29 Recommended RVUs: 0.40 Ratio:

Long Descriptor: Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass

Reference Set (y/n): N Global Period: 000 Frequency: 42,359 Impact: 4659

Source: 7 Year: 95 Public Comment Letter: 288

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ACC

Societies Wishing to Comment: ACR, AOA, ASIM, SCVIR

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
93539	30.5	1.5	4.5	29.7	13.9	0.4	0.4	10.1

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
93539	.	42338	.

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
93539	.	74.8	.

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
93539	cardiovascular disease	90.8
	group practices	2.2
	internal medicine	5.9

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
93539	410	2.4	ACUTE MYOCARDIAL INFARCTION
	411	7.2	OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE

AMA/Specialty Society RVS Update Process

Public Comments

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413	3.4	ANGINA PECTORIS
414	15	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
427	1.6	CARDIAC DYSRHYTHMIAS
428	1.8	HEART FAILURE
786	4	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS
V45	2.6	OTHER POSTSURGICAL STATES

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
93539							
ACC			000		0.29		

Harvard Data:

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
93539								
ACC		0.29				1.00	0.40	288

Harvard Data:

Comm	Pack95	Hrvtotwk	Notatw	Pret	Svdpre	itime	Notett	Imppt
93539								
ACC	000							

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hviadur	Icuvis	Offvis
93539									
ACC									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
93539									
ACC				0.40	0.29				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 93545 Global Period: XXX Current RVW: 0.29 Recommended RVW: 0.40

CPT Descriptor: Injection procedure during cardiac catheterization; for selective coronary angiography

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-60 year old man with exceptional chest pain of recent duration, heavy smoker (now or in past) with family history of heart attacks.

This is an add-on procedure during a cardiac catheterization that entails selecting, exchanging, if necessary, and positioning the proper catheter in each of the coronary arteries and then positioning the patient and the X-ray properly. The physician must decide on the most appropriate type and amount of contrast and injection method to obtain the needed data in the particular patient's situation. The catheter may occasionally be connected to the mechanical injector and the injection undertaken under very close supervision by the cardiologist. Generally, manual injections of contrast are used and the force and duration of these injections must be sufficient to assure full opacification of the target artery with duration sufficient to visualize the entire arterial system. Manual panning of the x-ray table must be expertly performed to assure complete visualization. Selection of angiographic angled views must be expertly determined to yield the necessary visual information the multi-branched coronary arterial system which is always in motion due to the continual movement of the beating heart. The conscious patient may experience a mild "hot flush" of varying intensity and be subject to potential serious cardiac arrhythmias and even fluid overload with possible heart failure and/or myocardial depression in addition to potential embolic phenomena during the injection or peri-injection. Air must be carefully eliminated from the catheter as air emboli can pose a significant risk to the patient. An additional risk during this type of angiogram is a dissection of the coronary artery which has the potential to produce arrhythmias, myocardial damage, even significant pericardial effusions which could lead to cardiac tamponade. Anxiety and allergic contrast reactions are often experienced and also must be coped with immediately and can produce an emergent situation. An immediate decision on the acceptability of the recorded angiogram must be made, and if not acceptable, a repeat angiogram must be considered. These coronary artery angiograms range from 4 to 10 cc's in volume and because multiple injections are typically required, consideration regarding contrast overload and also can become a significant factor in a patient with renal impairment and necessitate close follow-up and extra therapy such as fluid loading and diuretics to counteract the problems.

Description of Pre-Service Work: N/A

Description of Intra-Service Work: See clinical vignette above

Description of Post-Service Work: N/A

SURVEY DATA:Specialty: American College of CardiologySample Size: 114 Response Rate (%): 53 (47%) Median RVW: 0.4025th Percentile RVW: 0.33 75th Percentile RVW: 0.40 Low: 0.29 High: 0.58Median Pre-Service Time*: 0 Median Intra-Service Time*: 25.025th Percentile Intra-Svc Time*: 17.0 75th Percentile Intra-Svc Time*: 22.0 Low: 6.0 High: 30.0

* Time is reported in minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>N/A</u>	
ICU:	<u>N/A</u>	<u>N/A</u>
Other Hospital:	<u>N/A</u>	<u>N/A</u>
Office:	<u>N/A</u>	<u>N/A</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	93540	Injection procedure during cardiac cath for selective opacification of aortacoronary venous bypass grafts, one or more coronary arteries	0.43
2)	93542	Injection procedure during cardiac cath for selective right ventricular or right atrial angiography	0.29
3)	99245	Office consultation, level 5	2.96

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The physician work involved in the series of cardiac angiography injection codes varies depending on the nature of the structures being filmed and the difficulty in accessing these. This surveyed service, injection for selective coronary angiography, requires more work than most of the other services in the series.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Based on the comparative note above, the ACC recommends the median physician RVU of 0.40 be adopted.

Public Comments06-Jul-95

Code: 93545

1995 RVUs: 0.29

Recommended RVUs: 0.35

Ratio:

Long Descriptor: Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)

Reference Set (y/n): N Global Period: 000 Frequency: 641,667 Impact: 38500

Source: 11 Year: 94 Public Comment Letter: 288

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACC

Societies Wishing to Comment: ACR, AOA, ASIM, SCVIR

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
93545	34.1	2.8	8.6	43.5	9.5	0.3	1	9.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
93545	25409	670630	413.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
93545	92.6	76.8	-7.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
93545	cardiovascular disease	88.6
	group practices	3.3
	internal medicine	7.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
93545	410	3.1	ACUTE MYOCARDIAL INFARCTION
	411	6.4	OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE

AMA/Specialty Society RVS Update Process

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413	3.1	ANGINA PECTORIS
414	11.8	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
424	1.5	OTHER DISEASES OF ENDOCARDIUM
427	1.7	CARDIAC DYSRHYTHMIAS
428	2.1	HEART FAILURE
786	4.8	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
93545							
ACC		000	000	1.89	0.29	0.15	0.20

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
93545								
ACC	0.29	0.29	0.11	1.45	1.00	1.00	0.35	288

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notatt	Imppt
93545								
ACC	000	1.89		13	*	18		13

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
93545									
ACC		0.0		0	0.0		0	0.0	0.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
93545									
ACC		0		0.35	0.29	ca	3		0.073

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Lab and Pathology

The review of lab and pathology procedures primarily addressed CMD comments on codes that they identified as overvalued. In response, the College of American Pathologists (CAP), provided recommendations to the RUC to maintain or increase the RVUs for these codes. Based on survey results, comparisons to the final Harvard study results, comparisons to key reference services, and analysis of Medicare claims data, the RUC believes that CAP provided compelling evidence for maintaining the current values of these procedures and, for code 86327, for increasing the RVUs from their current level.

The American Society of Hematology (ASH), provided recommendations to the RUC on four codes. Based on survey results and comparisons to key reference services, the RUC increased the RVUs of all four codes. However, in two instances the RUC did not feel that the specialty society had provided enough compelling evidence to adopt the increase that the specialty society recommended.

The Medical Oncology Association of Southern California submitted comments to HCFA requesting increased RVUs for two bone marrow codes. Since no evidence was presented to support their comment, the RUC recommended maintaining the current value of these codes.

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KEY (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality)

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five-year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
38230	Bone marrow collection	3.16	4.22	In their public comments ASH noted that this procedure is undervalued, taking into account the amount of time associated with bone harvesting.	<p>The specialty society noted that this procedure is performed in the operating room under general anesthesia. The specialty society noted that the survey median was not reflective of the work intensity of this procedure which can vary by site depending on whether or not physicians were affiliated with major allogenic centers.</p> <p>The RUC felt that the specialty society did not present compelling evidence to increase the RVU of this procedure to 7.0. The RUC did feel that the survey median of 4.22 was a more accurate reflection of the work involved in this service.</p>	4
83020	Assay hemoglobin	0.37	0.37	The CMDs commented that the interpretation of this service required less time than a PA/Lateral chest x-ray which has a Harvard time of 5 minutes.	The specialty society reported that the interpretation and reporting of the electrophoretic pattern of hemoglobin represents the most specific method for determining the presence of hemoglobinopathy such as sickle cell anemia. The specialty society noted that the survey median total time for this procedure of 14 minutes, is well above the time it takes to interpret a chest x-ray. The specialty society is recommending 0.43, the survey median for this procedure. The RUC felt that compelling evidence was presented to maintain the current value of the code, but not to increase it.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
83912	Genetic examination	0.37	0.37	The CMDs commented that as more PCR tests become available, the interpretation of these reports will become easier. The time involved in interpreting these reports is the same as 94060[Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise. (0.31)]. 94060 has a Harvard time of 7 minutes.	<p>The specialty society reported that this procedure is the southern blot test. This test detects the DNA of a microbacteria in specimen. The pathologists survey results refuted the CMD claim that this service is comparable in time to 94060[Oxygen uptake, expired gas analysis; rest, indirect (separate procedure)]. Instead this service is more reflective of the reference services 80500[Clinical pathology consultation; limited, without review of patient's history and medical records (0.37)] and 85060[Blood smear, peripheral, interpretation by physician with written report (0.45)].</p> <p>The specialty society recommended an RVU of 0.40 which was the survey median. The RUC felt that compelling evidence was presented to maintain the current value of the code.</p>	2
84165	Assay serum proteins	0.37	0.37	The CMDs commented that the interpretation of this service required less time than a PA/Lateral chest x-ray which has a Harvard time of 5 minutes.	<p>CAP reported that the interpretation and report of this procedure involves several different professional services. First an agarose gel plate with the electrophoretic pattern of the patient and serum control pattern are compared by the pathologist. Then densitometer tracings of the patient control patterns are evaluated for abnormalities. The report of this evaluation would include a differential diagnosis of the pattern abnormalities that could require other laboratory studies. The survey median total time was 13 minutes for this procedure. The survey respondents placed the work of this service between the reference codes 80500[Clinical pathology consultation; limited, without review of patient's history and medical records (0.37)] and 85060[Blood smear, peripheral, interpretation by physician with written report(0.45)]. CAP recommended the survey median of 0.40 for this procedure. The RUC felt that compelling evidence was presented to maintain the current value of the code.</p>	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
84181	Western blot test	0.37	0.37	The CMDs commented that the interpretation of western blot tests has become easier as the quality and technique of the test have improved. They also note that an error in the interpretation of this test is no more significant than missing a tumor when reading a frontal chest x-ray 71020 (0.22).	The western blot test is used to detect antibodies specific for a particular protein in a mixture of antibodies and proteins. This test is the confirmatory test for HIV, which has significant implications for the physician and patient in the event of a misdiagnosis. In contrast to the CMD comments, CAP reports that this test has become more complex which is associated with an increased chance for the detection of false positives. CAP recommended the survey median of 0.39 for this procedure. The RUC felt that compelling evidence was presented to maintain the current value of the code, but not to increase it.	2
84182	Protein, western blot test	0.37	0.37	The CMDs commented that the interpretation of western blot tests has become easier as the quality and technique of the test have improved. They also note that an error in the interpretation of this test is no more significant than missing a tumor when reading a frontal chest x-ray 71020 (0.22).	CAP reported that this is another type of western blot test which uses immunological probe for band identification to detect the antigens for particular organism in a mixture of proteins. CAP recommended the survey median of 0.40 for this procedure. The RUC felt that compelling evidence was presented to maintain the current value of the code, but not to increase it.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
85095	Bone marrow aspiration	1.08	1.08	In their public comments to HCFA, the Medical Oncology Association of Southern California noted that they believe that CPT codes 85095[Bone Marrow; aspiration only] and 85102[Bone marrow biopsy, needle or trocar] are undervalued. Specifically, they cite the advancement of technology in cytogenetics, flow cytometry chemotherapy sensitivity assays, and immunohistochemistry, has made it necessary for oncologists, in the last 1-2 years, to acquire more specimens and perform additional steps to perform tests that can assist the physician in treatment of the cancer patient.	The specialty provided no compelling evidence to support their comment, so the RUC recommends that the current RVUs of these procedures be maintained.	2
85102	Bone marrow biopsy	1.37	1.37			2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
85390	Fibrinolysin screen	0.37	0.75	<p>The CMDs commented that the value of this procedure should be reduced on the basis that a fibrinolysin screen requires less time and expertise than the interpretation of PA/lateral chest x-ray 71020 (0.22), with a Harvard time of five minutes.</p> <p>In their public comment, ASH requested that the value of this procedure be increased to 1.19. ASH compared this service to 88331[Pathology consultation during surgery; with frozen section(s), single specimen], which has a relative value of 1.19 and Harvard time of 20-24 minutes.</p>	<p>In their presentation to the RUC CAP and ASH noted that this procedure is the evaluation of a coagulopathy. It was also noted that this procedure has never been surveyed and that its current value was assigned by HCFA. The specialty societies recommend an RVU of 1.20 which is the survey median for this procedure.</p> <p>The RUC agreed that the physician work of providing this service has changed during the past few years. The patients are more complex, the tests are more technical, and the physician is required to run more tests. However, the RUC did not feel that these changes warranted an increase in RVUs to 1.20. Instead the RUC believes that this service is comparable in physician work to the key reference service selected by the respondents, 88305[Level IV Surgical pathology, gross and microscopic examination] which has an RVU of 0.75. The RUC recommends 0.75 RVUs for CPT code 85390.</p>	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
85576	Blood platelet aggregation	0.37	0.37	The CMDs commented that the value of this procedure should be reduced on the basis that a fibrinolysin screen requires less time and expertise than the interpretation of PA/lateral chest x-ray 71020 (0.22), with a Harvard time of five minutes.	CAP reported that this procedure is the determination of platelet response to aggregating agents. The current value of this procedure was assigned by HCFA based on the general pathology clinical consultation code 80500. 85576[Platelet; aggregation (in vitro), each agent] was not studied by Harvard however, Harvard data on 80500 showed mean total times of 11-13 minutes, lower than the current survey total time of 18.5 minutes for 85576. Survey respondents rated the 85576 between the 80500[Clinical pathology consultation; limited, without review of patient's history and medical records] and the 85060[Blood smear, peripheral, interpretation by physician with written report] in terms of complexity. The survey time also exceeds the reference service chosen by the CMDs. CAP recommended an RVU of 0.50 for this procedure. The RUC felt that there was compelling evidence to support maintaining the current value of this procedure but not to increase it.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
86077	Physician blood bank service	0.37	0.94	In their public comment to HCFA, ASH requested that the RVU of this code be increased to 0.94.	<p>For their survey ASH selected 86078[Blood bank services; investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report (0.94)] as a reference service. ASH noted that the work of 86077[Blood bank services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report] and 86079[Blood bank services; authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report] are similar to 86078 and should have the similar relative values. Based on the results of their survey ASH recommended an RVU of 0.99, the survey median for this procedure. The RVU of 0.99 is higher than what ASH recommended to HCFA in their comment letter.</p> <p>The RUC felt that compelling evidence was presented to warrant an increased RVU for this code. However, the RUC determined that based on similarity of work to 86078, the RVU of 0.94 would be more appropriate.</p>	4

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
86079	Physician blood bank service	0.37	0.94	In their public comment to HCFA, ASH requested that the RVU of this code be increased to 0.94.	For their survey ASH selected 86078[Blood bank services; investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report (0.94)] as a reference service. ASH noted that the work of 86077[Blood bank services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report] and 86079[Blood bank services; authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report] are similar to 86078 and should have the similar relative values. ASH recommended an RVU of 0.94 for this procedure. The RUC felt that compelling evidence was presented to warrant an increased RVU for this code.	1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
86255	Fluorescent antibody; screen	0.37	0.37	The CMDs asked that the relative value for this procedure be reduced on the basis that the interpretation of the fluorescent antibody screen, each antibody, requires less time and physician work than interpretation of a PA/lateral chest x-ray. They also suggest that screens are always performed on 3 antibodies, and since the physician can report each antibody the total RVU 1.11 is excessive.	In response to the CMD comment, the specialty society noted that when performing 86255[Fluorescent antibody; screen, each antibody] and 86256[Fluorescent antibody; titer each antibody], there is no economy of scale if one section is done or three. The study of each auto-antibody is a study unto itself since different tissue/cells are used to demonstrate reactions for different antibodies. During this procedure microscopic examination is done on frozen tissue sections to detect fluorescence which would be given off by autoantibodies of various cell constituents. If fluorescence is detected than a fluorescent antibody titer is performed. The current value of this procedure was assigned by HCFA based on the value of the clinical pathology code 80500[Clinical pathology consultation; limited, without review of patient's history and medical records (0.37)]. The survey respondents rated 86255 slightly more complex than 80500, but slightly less complex than 85060[Blood smear, peripheral, interpretation by physician with written report (0.45)]. The recommended RVU is 0.40. The RUC felt that there was compelling evidence to support maintaining the current value of this procedure, but not to increase it.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
86256	Fluorescent antibody; titer	0.37	0.37	The CMDs asked that the relative value for this procedure be reduced on the basis that the interpretation of the fluorescent antibody screen, each antibody, requires less time a physician work than interpretation of a PA/lateral chest x-ray. They also suggest that screens are always performed on 3 antibodies, and since the physician can report each antibody the total RVU 1.11 is excessive.	In response to the CMD comment, the specialty society noted that when performing 86255 and 86256, there is no economy of scale if one section is done or three. The study of each auto-antibody is a study unto itself since different tissue/cells are used to demonstrate reactions for different antibodies. During this procedure microscopic examination is done on frozen tissue sections to detect fluorescence which would be given off by autoantibodies of various cell constituents. If fluorescence is detected than a fluorescent antibody titer is performed. The current value of this procedure was assigned by HCFA based on the value of the clinical pathology code 80500[Clinical pathology consultation; limited, without review of patient's history and medical records (0.37)]. The survey respondents rated 86256 slightly less complex than 85060[Blood smear, peripheral, interpretation by physician with written report (0.45)], and comparable to 86255[Deoxyribonucleic acid (DNA) antibody; native of double stranded]. The recommended RVU is 0.39. The RUC felt that there was compelling evidence to support maintaining the current value of this procedure, but not to increase it.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
86320	Serum immunoelectrophoresis	0.37	0.37	The CMDs commented that the value of this procedure should be reduced on the basis that a serum immunoelectrophoresis requires less time and expertise than the interpretation of PA/lateral chest x-ray 71020 (0.22), with a Harvard time of five minutes.	CAP reported that a serum immunoelectrophoresis involves the physician reviewing and interpreting dispersed patterns of patient serum and comparing those patterns to controls. Interpretation requires a judgement as to whether the shape and density of the sample is sufficiently different from the control to detect an abnormality. The median survey time was 16.5 minutes, well above the CMD radiology reference service. Survey respondents rated the complexity of this service the same as 85060[Blood smear, peripheral, interpretation by physician with written report (0.45)]. CAP recommended an RVU of 0.48 for this procedure. The RUC felt that there was compelling evidence to support maintaining the current value of this procedure, but not to increase it.	2
86325	Other immunoelectrophoresis	0.37	0.37	The CMDs commented that the RVU for this procedure be reduced, because they feel that 86325 is less time than 71020 - PA/lateral chest x-ray.	The specialty society noted that the current RVU for this procedure was assigned by HCFA. CAP also noted that the vignette for this code was studied by Harvard and had a mean time of 11 minutes, well above the time of 71020. CAP reported that this procedure is similar to 86320[Immunoelectrophoresis; serum] and should have a similar value. CAP recommended 0.45 for this procedure. The RUC felt that there was compelling evidence to support maintaining the current value of this procedure, but not to increase it.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
86327	Immunoelectrophoresis assay	0.37	0.45	The CMDs commented that the RVU for this procedure be reduced, because they feel that 86327[Immunoelectrophoresis; crossed (2-dimensional assay)] requires less time than 71020 - PA/lateral chest x-ray.	<p>The specialty society noted that the current RVU for this procedure was assigned by HCFA. CAP also noted that the vignette for this code was studied by Harvard and had a mean time of 11 minutes, well above the time of 71020. CAP reported that this procedure is for the separation and investigation of protein multimers. The crossed immunoelectrophoresis is a very low volume service with only a relatively small number of physicians providing these interpretations. CAP recommended an RVU of 0.60 for this procedure.</p> <p>The RUC did not feel that there was compelling evidence to increase the value of this procedure to 0.60. They determined that this service was similar in work to 86325[Immunoelectrophoresis; other fluids (eg, urine, CSF) with concentration] and suggested an increase to 0.45 for this procedure.</p>	4
86334	Immunofixation procedure	0.37	0.37	The CMDs commented that the RVU for this procedure be reduced, because they feel that 86334[Immunofixation electrophoresis] requires less time than 71020 - PA/lateral chest x-ray.	CAP reported that the CMDs noted that 86334 requires more expertise than the interpretation of a serum electrophoresis and cited 86325 and 86327[Immunoelectrophoresis; crossed (2-dimensional assay)]. CAP also noted that the serum electrophoresis vignette 86320[Immunoelectrophoresis; serum] was studied by Harvard and had a mean time of 11 minutes. CAP noted that this procedure is used to detect monoclonal processes in patient specimens. CAP recommended an RVU of 0.45 for this procedure. The RUC recommended maintaining the current value of this procedure, but not to increase it.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
88170	Fine needle aspiration	0.50	1.27	In a public comment submitted to HCFA the endocrine society noted that 88170(0.50) - fine needle aspiration and 88171(1.05) - deep tissue fine needle aspiration, are undervalued compared to the breast biopsy code 19100(1.27).	The ACR conducted a survey on codes 88170 and 88171 and noted that the majority of the survey respondents reported that the new technology associated with this procedure has not lessened physician work. Instead many respondents noted that because their patients are increasingly more complex, physician work has also increased. ACR noted that although the work involved for 88170 is similar to 19100, the risk of complication is greater with 88170. ACR recommended a value of 1.27, the same RVU as 19100[Biopsy of breast; needle core (separate procedure)] for these procedures. The RUC also agreed with the information presented by ACR, that suggested that these codes should be valued equal to one another. The RUC determined that the specialty society presented compelling evidence to recommend increased RVUs for these procedures.	1
88171	Fine needle aspiration	1.05	1.27			1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
88172	Evaluation of smear	0.60	0.60	The CMDs commented that the relative value of 88172[Evaluation of fine needle aspirate with or without preparation of smears; immediate cytohistologic study to determine adequacy of specimen(s)] should be reduced, since the immediate evaluation of a fine needle aspirate requires no more time than the interpretation of cytopathological fluids as described by code 88104[Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation (0.56)], with a Harvard time of 17 minutes.	<p>CAP noted that the immediate cytohistologic evaluation to determine FNA specimen adequacy generally requires the presence of the pathologist at the patient bedside or the CAT scan facility. CAP noted that their survey median for this service is 1.10, which is twice the RVU of 88104 and somewhat less than the RVU of 88331[Pathology consultation during surgery; with frozen section(s), single specimen (1.19)]. CAP recommended an RVU of 1.10 for this procedure.</p> <p>The RUC noted that there was compelling evidence to maintain the current value for this procedure, but not to increase it.</p>	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
88173	Interpretation of smear	1.08	1.08	The CMDs commented that the relative value of 88173[Evaluation of fine needle aspirate with or without preparation of smears; interpretation and report] should be reduced, since the FNA of the breast requires no more time than the interpretation of cytopathological fluids as described by code 88104(0.56), with a Harvard time of 17 minutes.	CAP reported that a fine needle aspiration (FNA) is usually performed to establish a diagnosis on a tumor. The evaluation and definitive diagnosis of an FNA involves the examining a minimum of 8-10 slides. CAP noted that in their comments to HCFA the only service that was identified as undervalued was 88173. Specifically, CAP requested that the RVU for 88173 be increased from 1.08 to 1.60, because there has been a change in the physician work since it was studied by Harvard in 1990. New technology has made it possible to identify and sample lesions at an earlier stage of the disease process. These "early" lesions contain fewer diagnostic cells and require more physician effort to arrive at a diagnosis. The CMDs stated that they felt the time and expertise to interpret 88173 was comparable to 88104, and recommended that the RVU of 88173 be reduced from 1.08 to 0.56. CAP conducted a survey of 88173 the results of which indicate a median of RVU of 1.59, which is almost three times the RVU of 88104, clearly indicating that the physician work of 88173 is not comparable to 88104. CAP recommended an RVU of 1.59 for this procedure. The RUC noted that there was compelling evidence to maintain the current value for this procedure, but not to increase it.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
88180	Cell marker study	0.36	0.36	The CMDs commented that the RVU of the procedure be decreased based on the number of cell surface markers billed for each submission of this code.	CAP reported that 88180 [flow cytometry, each cell surface marker], requires significant technical skill. This code generally determines whether or not a patient has leukemia, lymphoma, or an immunodeficiency state such as AIDS. Flow cytometry is specialized and not widely provided. The patients who receive this treatment are generally more complex than 5 years ago. The CAP survey showed a median time of 25 minutes per cell surface marker or a total of 250 minutes for the 10 marker average stated by the CMDs as the average case. This is significantly more time than that involved in a tracheostomy (31600) which is 82 minutes or one hour of critical care. CAP recommended an RVU of 0.80 for this procedure. The RUC noted that there was compelling evidence to maintain the current value for this procedure, but not to increase it.	2
88182	Cell marker study	0.77	0.77	The CMDs commented that the RVU of the procedure be decreased based on the number of cell surface markers billed for each submission of this code.	CAP reported that the procedure described by 88182[Flow cytometry; cell cycle or DNA analysis], is two separate tests which require significant technical skill. This code represents new technology with significant prognostic implications in many cell tumor types. 88182 describes 2 types of service, DNA cell cycle and ploidy analysis. The CMDs suggested that the RVU be reduced to 0.34 for this procedure, because on average, the physician would bill 10 units per claim, and 10 times 0.77 is 7.70, an extreme for this code. The basis for this reduction is erroneous since 88182 describes two types of service, DNA cell cycle and ploidy analysis. The maximum number of units for any single patient specimen would be two; two times the current relative value unit for 88182 is 1.54. CAP recommended an RVU of 0.75 for this procedure. The RUC noted that there was compelling evidence to maintain the current value for this procedure, but not to increase it.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	RUC/ Rationale	Key
88311	Decalcify tissue	0.24	0.24	The CMDs requested that the physician work relative value unit for this procedure be reduced to 0.00 with the rationale that is a technical procedure that does not require physician work.	CAP reports that decalcification is a time critical procedure that requires physician work. The time is different depending on the specimen based on variables of size and density, and must be established by empirical testing which is done by the physician. Underdecalcification results in a specimen which is difficult to section yielding extensive histological artifact. Overcalcification results in loss of nuclear and cellular detail. In order to achieve optimal decalcification the physician must test the specimen periodically. CAP recommended that the current RVU of 0.24 be maintained. The RUC noted that there was compelling evidence to maintain the current value for this procedure.	2
89060	Exam, synovial fluid crystals	0.37	0.37	The CMDs asked that the relative value be reduced to 0.16 because the time and expertise required to examine fluid for crystals is no greater than the interpretation of a PA/lateral chest x-ray 71020(0.22) with a Harvard time of 5 minutes.	CAP reported that this interpretation involves the evaluation of wet preparations of body fluids, including joint and biliary fluids, and is useful in the determination of crystal material within joint fluid. The specimen is examined first by the pathologist who notes the gross characteristics. CAP noted that the median survey time for this procedure from their survey is 15 minutes, well above the 5 minutes of 71020. Based on the median survey results, CAP recommended an RVU of 0.45 for this procedure. The RUC noted that there was compelling evidence to maintain the current value for this procedure, but not to increase it.	2

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

Code: 38230 Global Period: 010 Current RVW: 3.16 Recommended RVW: 7.0

CPT Descriptor: Bone marrow harvesting for transplantation.

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 42 year old woman with Stage II breast cancer involving 15 axillary lymph nodes is admitted for marrow harvest for high dose chemotherapy. She has a hematocrit of 34. All other laboratory results are normal. Under general anesthesia, she has about 150 bone marrow aspirations from the posterior iliac crests, collecting about a liter of marrow for transplantation after high dose chemotherapy. During the procedure, she requires 2 units of packed red cells to replace blood and marrow loss. At the completion of the procedure, a pressure dressing is applied over the four 1 cm incisions. She leaves the OR for the recovery room in stable condition with an order for frequent monitoring of vital signs and narcotics for pain relief. That evening, she is transferred to the oncology unit from the recovery room. Her evening hematocrit is 29. The next morning, the patient is prepared for hospital discharge. The dressing is removed and adhesive bandages are applied. The morning hematocrit is 30. A prescription for narcotics is written and she is given an appointment to return for a check-up.

Description of Pre-Service Work:

Physical examination; review of laboratory results.

Description of Intra-Service Work:

Approximately four 1 cm incisions; collection of about 150 bone marrow aspirations from posterior iliac crests; transfusion of red cells; application of pressure dressing.

Description of Post-Service Work:

Re-evaluation of vital signs; review post-procedure laboratory results; change dressing; write prescription for narcotics; follow-up office visit.

SURVEY DATA:

Specialty: Hematology/Oncology

Sample Size: 58 Response Rate (%): 45% Median RVW: 4.22

Percentile RVW: 3.16 75th Percentile RVW: 7.0 Low: 2.0 High: 18

Median Pre-Service Time: 60 minutes Median Intra-Service Time: 90 minutes

25th Percentile Intra-Svc Time: 70 minutes 75th Percentile Intra-Svc Time: 90 Low: 60 High: 150

Median Post-Service Time:	<u> </u>	<u> </u>
Day of Procedure:	<u>30</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>20</u>	<u>1</u>
Office:	<u>15</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	85095	Bone marrow aspiration	1.08
2)	85102	Bone marrow biopsy	1.37
3)	99213	Office/outpatient visit, established	0.55
4)	99223	Initial hospital care	2.57

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

SEE EXPLANATION BELOW

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Bone marrow harvesting is a 90 minute operating room procedure, performed under general anesthesia, and followed by an office visit during the 10-day global period. During the procedure, bone marrow is aspirated approximately 150 times from the posterior iliac crests.

The current RVU for bone marrow harvesting [3.16 RVUs] clearly undervalues this service. As a point of comparison, the current work value of a level 3 hospital admission [CPT 99223], which is assumed to involve 70 minutes of floor time, is 2.57 RVUs and a Level 3 office visit [CPT 99213] is 0.55 RVUs. It is not credible that an OR procedure of this complexity is valued similarly to, if not less than, E&M services of comparable duration.

Work involved in harvesting is similar in nature to that of a bone marrow aspiration [CPT 85095 – 1.08 RVUs] and a bone marrow biopsy [CPT 85102 – 1.37 RVUs]. The primary differences relate to 1) intra-service time and 2) post-service visits.

1. A bone marrow aspiration or biopsy typically takes 15 minutes; harvesting requires on average 90 minutes of intra-service work, a six-fold increase in time of procedure.
2. Bone marrow aspiration and biopsy do not include a global period; bone marrow harvesting has a 10 day global period during which one office visit is anticipated.
3. Intensity is generally greater for harvesting than for aspirations; psychological stress associated with harvesting is greater than for biopsies.

In developing a recommendation, ASCO relied on comparison with aspiration and biopsy codes, and included work associated with the subsequent visit.¹

1. Based on a 15 minute procedure, aspirations are valued at .072 RVU/minute.
2. Based on a 15 minute procedure, biopsies are valued at .091 RVU/minute.
3. The intensity (RVU/minutes) reflected in the existing RVUs for aspirations and biopsies implies, for the 90 minute harvesting procedure, an RVU of 6.48 - 8.19.
4. Accounting for one level 3 visit during the global period would increase the appropriate range for the bone marrow harvesting RVU to between 7.03 and 8.74.
5. The 75th percentile of the RVU recommended by survey participants is 7.0, comparable to the intensity comparison with bone marrow aspiration.

¹ Data related to pre- and post-service times were difficult to interpret. It appears that many of the physicians surveyed included total time the patient was in the care of a health care provider, not just that which directly involved the doctor. As a result, ASCO's recommendations do not reflect time and intensity associated with pre- and post-service time on the day of the procedure. As such, the Society views its recommendation as a "floor."

RVU	DISTRIBUTION	FREQUENCY
2.0	■	1
2.20	■	1
3.0	■■	2
3.16	■■■	3
3.25	■■	2
3.5	■	1
4.0	■	1
4.2	■	1
4.22	■	1
4.6	■	1
5.5	■	1
5.59	■	1
6	■	1
6.46	■	1
6.5	■	1
7.0	■	1
8.0	■	1
10.0	■■■	3
10.3	■	1
18	■	1
MEDIAN	4.22	
25TH PERCENTILE	3.16	
75TH PERCENTILE	7.0	

MINUTES	DISTRIBUTION	FREQUENCY
10	■	1
20	■	1
30	■■■■	4
45	■	1
60	■■■■■	6
80	■	1
90	■■	2
120	■■■■■	5
150	■■■	3

MEDIAN	60		
25TH PERCENTILE	30		
75TH PERCENTILE	120		

	MINUTES	DISTRIBUTION	FREQUENCY
	60	■■■■■	5
	70	■	1
	75	■■■■	4
	90	■■■■■■■■■	9
	120	■■■■■	5
	150	■	1
MEDIAN	90		
25TH PERCENTILE	70		
75TH PERCENTILE	90		

Bone marrow harvesting

Post-Service Time
Day of the Procedure

38230

MINUTES	DISTRIBUTION	FREQUENCY
5	■	1
15	■	1
20	■■■	3
30	■■■■■■■■■■■	11
45	■	1
50	■■	2
60	■■	2
90	■	1
135	■	1
180	■■	2

MEDIAN	30		
25TH PERCENTILE	30		
75TH PERCENTILE	50		

	TOTAL TIME (MINUTES)	DISTRIBUTION	FREQUENCY
	0	■■■■■■■■■■■■■■■■■■■■ ■	14
	10	■	1
	30	■■	2
MEDIAN	0		
25TH PERCENTILE	0		
75TH PERCENTILE	0		

Bone marrow harvesting

Post-Service Time
Hospital Time

38230

	TOTAL TIME (MINUTES)	DISTRIBU -TION	FREQUENCY
	0	■■■	3
	10	■■■	3
	15	■■	2
	20	■■	2
	30	■■■■■■■■	8
	120	■	1
MEDIAN	20		
25TH PERCENTILE	10		
75TH PERCENTILE	30		

Bone marrow harvesting

Post-Service Time
Office Time

38230

	TOTAL TIME (MINUTES)	DISTRIBU -TION	FREQUENCY
	10	■■■	3
	15	■■■■■■■■	8
	20	■■	2
	30	■■■■	4
	45	■	1
MEDIAN	15		
25TH PERCENTILE	15		
75TH PERCENTILE	30		

	NO. OF VISITS	DISTRIBU-TION	FREQUENCY
	1	■■■■■■■■ ■■■■■■■■	16
	2	■■	2
MEDIAN	1		
25TH PERCENTILE	1		
75TH PERCENTILE	1		

	MENTAL EFFORT & JUDGEMENT	DISTRIBUTION	FREQUENCY
	1	■	2
	2	■■■■■	5
	3	■■■■■■■■■	9
	4	■■■■■	5
	5	■■■	3
MEDIAN	3		
25TH PERCENTILE	2		
75TH PERCENTILE	4		

Bone marrow harvesting Technical Skills & Physical Effort 38230

	Technical Skills & Physical Effort	DISTRIBUTION	FREQUENCY
	1.5	■	1
	2	■	1
	3	■■■■■■■■■■ ■	12
	4	■■■■■■■	7
	5	■■■	3
MEDIAN	3		
25TH PERCENTILE	3		
75TH PERCENTILE	4		

Bone marrow harvesting

5 YEARS

38230

Has work changed in the past 5 years?

YES	NO
8	16

Bone marrow harvesting

TYPICAL PATIENT

38230

Does the Typical Service/Patient describes your typical patient?

YES	NO
15	8

Public Comments

30-Jun-95

Code: 38230

1995 RVUs: 3.16

Recommended RVUs: 7.00

Ratio:

Long Descriptor: Bone marrow harvesting for transplantation

Reference Set (y/n):

N

Global Period: 010

Frequency: 153

Impact: 588

Source: 1

Year: 92

Public Comment Letter: 336

Reference Services:

CMD Comment:

--

Societies Wishing to Survey: ASCO

Societies Wishing to Comment: ASH, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
38230	0	0	0	0	50	0	50	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
38230	139	164	8.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
38230	53.2	54.9	0.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
38230	general surgery	4.9
	group practices	14.6
	hematology/oncology	34.1
	internal medicine	40.2
	orthopedic surgery	2.4
	pediatrics	2.4

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
38230	202	12.5	OTHER MALIGNANT NEOPLASMS OF LY

Public Comments

30-Jun-95

585	12.5	CHRONIC RENAL FAILURE
998	12.5	OTHER COMPLICATIONS OF PROCEDUR
V07	12.5	NEED FOR ISOLATION AND OTHER PROP
V42	12.5	ORGAN OR TISSUE REPLACED BY TRAN

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
38230							
ASCO			010	.	3.16	.	3.16
ASH			010	.	3.16	.	3.16

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
38230								
ASCO	3.16	3.16	.	1.00	1.00	1.00	INCR	329
ASH	3.16	3.16	.	1.00	1.00	1.00	7.00	336

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
38230								
ASCO	010	.	.	.	.	.	.	.
ASH	010	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
38230									
ASCO
ASH

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
38230									
ASCO	.	.		INCR	3.16				
ASH	.	.		7.00	3.16				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 83020 Global Period: N/A Current RVW: 0.37 Recommended RVW: 0.43

CPT Descriptor:

Hemoglobin, electrophoresis (eg, A2, S, C)-interpretation and report.

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.16 on the basis that interpretation of hemoglobin electrophoresis requires less time and expertise than interpretation of a PA and lateral chest x-ray; the time and skill involved, once learned, is significantly less than the time and skill involved in evaluation and management of a patient for level 99212. The current value for the 71020 PA and lateral is 0.22 and the Harvard total time is 5 minutes. The current value of the 99212 is 0.38 and the CPT time is 10 minutes face-to-face.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Evaluation and report of hemoglobin electrophoresis and related laboratory data from a three year old child with mild anemia and reduced MCV.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology - College of American Pathologists

Sample Size: 28/45 Response Rate (%): 62% Median RVW: 0.43

25th Percentile RVW: 0.39 75th Percentile RVW: 0.58 Low: 0.13 High: 1.20

Median Pre-Service Time: 3 min. Median Intra-Service Time: 7 min.

25th Percentile Intra-Svc Time: 4 min. 75th Percentile Intra-Svc Time: 12.5 min. Low: 2 High: 40 min.

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	
		CPT Code: <u>83020</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
2)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
83020	3	7	4	3	2	2
80500	3	4.5	4	3	2	3
85060	2	6	3	3	2.5	2

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The interpretation and reporting of the electrophoretic pattern of hemoglobin represents the most specific method of determining the presence of a hemoglobinopathy. The electrophoretic plate is interpreted together with a chemical determination of the hemoglobin A2 level and peripheral blood red cell parameters to determine which if any abnormal hemoglobins are present and to diagnose the hemoglobinopathy. The collation of this data and ultimate narrative report for the medical record constitutes the interpretive service for this code. On certain occasions, such as a preoperative evaluation of a possible hemoglobinopathy, the service may require that the interpreting physician discuss the case with the patient's attending physician.

The survey median total time for interpretation of the hemoglobin electrophoresis is 14 minutes, well above the time of the CMD's radiology reference service time and above the intra-service time for the 99212 office visit that has a value of 0.38. Survey respondents rated the 83020 comparable in complexity to their chosen reference services but the 83020 median time is greater than the total times of each of these two references. The survey median physician work value for the 83020 is 0.43, between the values of the two reference services chosen by survey respondents.

Survey respondents agreed that the work of performing this service has not changed in the past five years and that the survey vignette describes their typical patient.

The College of American Pathologists recommends a physician work relative value of 0.43 for the hemoglobin electrophoresis interpretation based on the median survey value and comparison to reference services.

E:\USER\JAC\SURVEY95\SUM83020

CMD Comments

06-Jul-95

Code: 83020

1995 RVUs: 0.37

Recommended RVUs: 0.16

Ratio: -0.57

Long Descriptor: Hemoglobin, electrophoresis (eg, A2, S, C)

Reference Set (y/n): N

Global Period: XXX

Frequency: 94,575

Impact: -19860.75

Source: 2

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
83020			
	71020 CHEST X-RAY	0.22	XXX
	99212 OFFICE/OUTPATIENT VISIT, EST	0.38	XXX

CMD Comment:

Interpretation of hemoglobin electrophoresis requires less time and expertise than interpretation of a PA and lateral chest X-ray. The time and skill involved, once learned, is significantly less than the time and skill involved in Evaluation and Management of a patient for level 99212.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD RD	Rural
83020	42.6	9.1	16.8	60.3	9.6	0.3	0.3	9.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
83020	60823	120228	40.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
83020	13.5	3.2	-5.2

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
83020		
	general/family practice	3.7
	internal medicine	2.7
	other nonphysician prov	82.6
	pathology	4.7

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
83020		
250	7.1	DIABETES MELLITUS
285	1.2	OTHER AND UNSPECIFIED ANEMIAS
401	1.5	ESSENTIAL HYPERTENSION
V72	8.3	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
83020							
CMD			XXX		0.00		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
83020								
CMD							0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
83020								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
83020									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
83020									
CMD				0.16	0.00				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 83912 Global Period: NA Current RVW: 0.37 Recommended RVW: 0.40

CPT Descriptor: Nuclear molecular diagnostics; interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.30 on the basis that nuclear molecular diagnostics interpretation and report is a new field and that as more PCR tests have become available interpretation is significantly easier. CMDs said that the time involved in interpreting the test requires no more time than interpretation of a before and after bronchodilator study and cited two reference services: 72050 Radiologic examination, spine, cervical; minimum of four views (RV=0.31) and 94060 Bronchospasm evaluation: spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), and/or maximal voluntary ventilation, before and after bronchodilator (aerosol or parenteral) or exercise (RV=0.31). The 94060 Bronchodilator study was studied by Harvard and has a total time of 7 minutes from that study. The radiology reference apparently was not studied by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Using PCR, evaluation and report of DNA probe study of vaginal swab obtained from pregnant 28 year old suspected of gonococcal infection.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology - College of American Pathologists

Sample Size: 16/16 Response Rate (%): 100% Median RVW: 0.40

25th Percentile RVW: 0.37 75th Percentile RVW: 0.50 Low: 0.30 High: 0.90

Median Pre-Service Time: 5 min. Median Intra-Service Time: 10 min.

25th Percentile Intra-Svc Time: 5.5 75th Percentile Intra-Svc Time: 15 Low: 1 High: 180

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	
CPT Code: <u>83912-26</u>		

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
2)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
83912	5	10	5	3.5	2.5	3
80500	0	12.5	1	3.5	2.5	3.5
85060	5	12	5	3	3	2

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The 83912 code is for interpretation of molecular diagnostics, tests performed to detect the presence of a specific segment of DNA code. In the testing/technical process, a test specimen, eg., a vaginal swab, is treated to isolate the DNA present, containing, in part, the DNA from the putative infectious organism. This DNA is heated to separate the strands of the double helix. Before it cools (and thus reforms the double helix) a sample of "tagged" single strand DNA from gonococcus (in this vignette) is added. The DNA is allowed to anneal and this permits complementary fragments to form double helices. If tagged test DNA is incorporated in these double helices, this is evidence that the test organism that served as the origin of the test DNA was present in the original patient sample. Polymerase chain reaction (PCR) is a means of amplifying small amounts of DNA to make detection more sensitive. Detection is by electrophoresis to separate DNA fragments and, by identifying the "tag," to look at the distribution of "tagged" fragments. Sufficient incorporation of DNA from a specific organism is interpreted as indicative of presence of an organism.

Interpretation of the results of the technical process requires intimate knowledge of the process, an understanding of the potential microbiology involved, and understanding of the amount and pattern of double helix formation (DNA segments) necessary to indicate significant clinical presence. For each organism (and DNA probes for new ones are constantly being developed) the DNA segments are unique and it is necessary for the physician to have a detailed knowledge of the various DNA patterns.

The median survey total time for the molecular diagnostics interpretation is 20 minutes. Survey respondents chose the general clinical pathology consultation service, 80500, and the peripheral blood smear interpretation service, 85060, as references and placed the value of the 83912 between these two services. The total time given for the 80500 is 13.5 , with 22 minutes given for the 85060. The three services were reported to be generally comparable in complexity. The CMDs' chosen bronchodilator reference service is significantly lower in total time.

This is a very low volume service. Of the 16 provider/respondents, 14 indicated that the work of performing the service has changed in the past five years, but there was a split as to whether the new technology has become more familiar. Most respondents said that there has been no change in patient complexity. Survey respondents also indicated no change in site-of-service, although the BMAD data show an increase in the percentage of inpatient volume from 1992 to 1994. . Seventy-five percent of survey respondents said the survey vignette describes their typical patient.

The College of American Pathologists recommends a physician work value of 0.40 for the molecular diagnostics interpretation based on median survey data and comparison to reference services.

CMD Comments

06-Jul-95

Code: 83912 1995 RVUs: 0.37 Recommended RVUs: 0.30 Ratio: -0.19

Long Descriptor: Nuclear molecular diagnostics; interpretation and report

Reference Set (y/n): N Global Period: XXX Frequency: 5,826 Impact: -407.82

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
83912			
	72050 X-RAY EXAM OF NECK SPINE	0.31	XXX
	94060 EVALUATION OF WHEEZING	0.31	XXX

CMD Comment:

Nuclear molecular diagnostics, interpretation and report is a new field. As more PCR tests have become available, interpretation is significantly easier. The time involved in interpreting the test requires no more time than the interpretation of a before and after bronchodilator study.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
83912	30.8	6.8	13.9	58.9	10.3	3.4	7.5	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
83912	2984	6192	44.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
83912	7.6	23.2	7.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
83912		
	group practices	9.8
	other nonphysician prov	41.8
	pathology	43.7

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
83912		
070	1.4	VIRAL HEPATITIS
162	1	MALIGNANT NEOPLASM OF TRACHEA, BRONCHUS, AND LUNG
202	2.7	OTHER MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE
573	2.2	OTHER DISORDERS OF LIVER
789	1	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
792	1.7	NONSPECIFIC ABNORMAL FINDINGS IN OTHER BODY SUBSTANCES
V42	1	ORGAN OR TISSUE REPLACED BY TRANSPLANT
V72	6.7	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
83912							
CMD			XXX		0.00		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
83912								
CMD							0.30	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
83912								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuis	Offvis
83912									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
83912									
CMD				0.30	0.00				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 84165 Global Period: N/A Current RVW: 0.37 Recommended RVW: 0.40

CPT Descriptor:

Protein, electrophoretic fractionation and quantitation - interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs requested a reduction in relative value to 0.16 on the basis that the time involved in interpretation of serum protein electrophoresis is less than that in interpretation of a PA and lateral chest x-ray, none of the services provided for the interpretation of serum protein electrophoresis are greater than the interpretation of the x-ray, and the time and effort involved is definitely less than evaluation of a patient in an office visit level 99212. The current relative value of the 71020 PA and lateral x-ray is 0.22 and the Harvard time is 5 minutes. The value of the 99212 is 0.38 and the CPT time is 10 minutes face-to-face.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Evaluation and report of protein electrophoresis and related laboratory data from a 59 year old man with elevated total serum protein and bony defects of the skull.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 30/35 Response Rate (%): 86% Median RVW: 0.40

25th Percentile RVW: 0.37 75th Percentile RVW: 0.50 Low: 0.16 High: 1.00

Median Pre-Service Time: 3 min. Median Intra-Service Time: 5 min.

25th Percentile Intra-Svc Time: 4 min. 75th Percentile Intra-Svc Time: 10 min. Low: 1.4 min High: 18 min.

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	

CPT Code: 84165

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
2)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
84165	3	5	5	3	3	3
80500	5	6.5	4	3	2	3
85060	6.5	10	8	4	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also

describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The interpretation and report of this laboratory procedure involves several different professional services. An agarose gel plate containing the patient's electrophoretic pattern and a serum protein control pattern provided by the laboratory technical staff are compared by the pathologist. The densitometer tracings of the patient control patterns are then evaluated and any abnormality in one of more of the five peaks usually present on such a pattern is described with a subsequent written narrative report. This report would include a differential diagnosis of the pattern abnormalities noted and may require an evaluation of other laboratory studies including hematologic, serologic and biochemical data as well as demographic data obtained through the laboratory computer system. Any possible technical problems noted in either the control or patient data would also need to be evaluated in consultation with the laboratory staff.

The survey median total time of 13 minutes for the 84165 is well above the time for the radiology reference service chosen by the CMDs and above the intra-service time for the 99212 office visit that has a value of 0.38. Survey respondents chose the 80500 general clinical pathology consultation service and the 85060 peripheral blood smear interpretation as their reference services and placed the complexity of the 84165 between those two services. The median work value for the 84165 is 0.40, compared to 0.37 and 0.45 for the two survey reference services.

The College of American Pathologists recommends a physician work relative value of 0.40 for the 84165 protein electrophoresis interpretation based on the survey median and comparison to reference services.

E:\USER\JAC\SURVEY95\SUM84165

CMD Comments

06-Jul-95

Code: 84165

1995 RVUs: 0.37

Recommended RVUs: 0.16

Ratio: -0.57

Long Descriptor: Protein; electrophoretic fractionation and quantitation

Reference Set (y/n): N

Global Period: XXX

Frequency: 441,079

Impact: -92626.59

Source: 2

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
84165			
	71020 CHEST X-RAY	0.22	XXX

CMD Comment:

Time involved in interpretation of serum protein electrophoresis is less than the interpretation of PA and lateral chest X-ray. None of the services provided for the interpretation of serum protein electrophoresis are greater than the interpretation of a PA and lateral chest X-ray, and the time and effort involved is definitely less than the evaluation of a patient for an office visit 99212 level (0.38).

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
84165	51.2	11.7	13.1	59.4	6.1	0.2	0.9	5.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
84165	371519	490008	14.8

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
84165	13.6	15.5	0.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
84165		
	group practices	3.8
	other nonphysician prov	68.8
	pathology	24

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
84165			

CMD Comments

06-Jul-95

203	1.2	MULTIPLE MYELOMA AND IMMUNOPROLIFERATIVE NEOPLASMS
273	1.3	DISORDERS OF PLASMA PROTEIN METABOLISM
285	1	OTHER AND UNSPECIFIED ANEMIAS
401	1	ESSENTIAL HYPERTENSION
V72	8.5	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
84165							
CMD			XXX		0.00		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
84165								
CMD							0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
84165								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
84165									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
84165									
CMD				0.16	0.00				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 84181 Global Period: NA Current RVW: 0.37 Recommended RVW: 0.39

CPT Descriptor:

Western blot, with interpretation and report, blood or other body fluid

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.16 on the basis that interpretation of Western Blot tests has become easier as the quality and technique of the test has improved. Error in interpretation of Western Blot testing carries no greater significance than error in interpretation of a chest x-ray of a patient with possible malignancy or tuberculosis. CMDs chose a Reference Service of 71020 Radiologic examination, chest, two views, frontal and lateral (RV=0.22).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Evaluation and report of Western blot pattern in a patient with repeatedly reactive HIV-1 antibody EIA who had multiple transfusions in the late 1970s.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology - College of American Pathologists

Sample Size: 26/26 Response Rate (%): 100% Median RVW: 0.39

25th Percentile RVW: 0.37 75th Percentile RVW: 0.60 Low: 0.10 High: 1.30

Median Pre-Service Time: 7.5 min. Median Intra-Service Time: 7 min.

25th Percentile Intra-Svc Time: 3 75th Percentile Intra-Svc Time: 15 Low: 1 High:

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	

CPT Code: 84181-26

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
2)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
84181	7.5	7	5	3.5	3	3
80500	2.5	5	5	3	2	2
85060	1	12	1	3	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also

describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Western Blot testing is used to detect the antibodies specific for a particular protein in a mixture of antibodies and proteins. Typically a mixture of microbial antigen proteins derived from a pure microbial culture is electrophoresed to separate the individual protein species. A strip containing the protein species is then "blotted" against a material containing test patient serum. Antibodies specific for individual proteins in the original mixture will form immune complexes and precipitate at the location of the electrophoresed protein component. Excess non-precipitated protein is washed away and the strip is stained to reveal specific bands of precipitate that are given numbers corresponding to their molecular weight.

The interpreting physician must have a knowledge of the antibodies considered specific for a particular organism, as these studies permit discrimination between non-specific antibodies related to a particular class of organisms, eg., spirochetes, and those for a specific organism such as Borrelia bergdorffii. The physician reviews one or more electrophoretic strips and compares the patient study with the control to determine the presence of specific bands. The presence of the bands is a means of indicating the immune status of the patient. Precipitation bands are indicative of the antibody specific to individual proteins derived from the microbial agent in question.

Difficulties in interpretation arise when the test results fit neither the positive nor the negative criteria, perhaps as a result of an abnormal patient response or the presence of an abnormal or different microbial antigen preparation. Western Blot studies for new or different organisms present still new problems. The interpreting physician must understand the reasons for antigen variability (batch to batch) depending on the specific strain used to prepare the antigen mixture.

The CMDs statement that interpretation of Western Blot testing has become easier as the quality and technique of the test has improved is incorrect. The Western Blot is a dynamic test with constant changes as new knowledge is gained and information about new organisms is defined. While the test itself has become more widely available with technological advance, the skills needed and work involved in interpretation of the test results are at least as demanding as previously. Patients who are being studied are also being treated by a variety of modalities, and their disease progresses to different stages before being arrested, making interpretation ever more difficult.

Survey responses are split on whether the work has changed in the last five years, and among those who indicated a change the responses are split as to whether the service is more or less familiar/difficult, probably reflecting differences in familiarity with the service five years ago. Seventy percent of respondents agreed that the vignette described their typical patient.

The current value of 0.37 for this interpretation was assigned by HCFA based on the value of the general clinical pathology consultation code 80500. The 84181 was not studied by Harvard or otherwise surveyed until now. The survey data from Harvard on the 80500 showed mean total times of 11-13 minutes, lower than the current survey total time of 19.5 minutes for the 84181. This survey time significantly exceeds the times for the two reference services chosen by the CMDs. Survey respondents chose the 80500 clinical pathology consultation and the 85060 peripheral blood smear interpretation as reference services, with values of 0.37 and 0.45, respectively, and assigned a median value of 0.39 to the 84181.

The College of American Pathologists recommends a physician work relative value of 0.39 for the 84181, Western Blot interpretation, based on the survey median and comparison to reference services.

CMD Comments

06-Jul-95

Code: 84181

1995 RVUs: 0.37

Recommended RVUs: 0.16

Ratio: -0.57

Long Descriptor: Protein; Western Blot, with interpretation and report, blood or other body fluid

Reference Set (y/n): N Global Period: XXX Frequency: 1,542 Impact: -323.82

Source: 7 Year: 94 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
84181			
	71020 CHEST X-RAY	0.22	XXX

CMD Comment:

The interpretation of Western Blot tests has become easier as the quality and technique of the test has improved. Error in interpretation of Western Blot testing carries no greater significance than error in the interpretation of a chest X-ray of a patient with possible malignancy or tuberculosis.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
84181	48.6	0	2.7	70.3	2.7	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
84181	.	1152	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
84181	.	0.3	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
84181		
	general/family practice	2.6
	geriatric medicine	2.1
	group practices	9.4
	other nonphysician prov	84.7

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

	ICD9	Pct of Time Used	ICD9 Descriptor
84181			
	088	8.1	OTHER ARTHROPOD-BORNE DISEASES
	716	2	OTHER AND UNSPECIFIED ARTHROPATHIES
	799	4.1	OTHER ILL-DEFINED AND UNKNOWN CAUSES OF MORBIDITY AND MORTALITY
	V72	4.7	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
84181								
	CMD			XXX		0.00		

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
84181									
	CMD							0.16	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
84181									
	CMD	XXX							

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
84181										
	CMD									

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
84181										
	CMD				0.16	0.00				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 84182 Global Period: NA Current RVW: 0.37 Recommended RVW: 0.4

CPT Descriptor:

Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.16 on the basis that this is another method of performing a Western Blot test and the rationale for reduction is the same as for 84181: The interpretation of Western Blot tests has become easier as the quality and technique of the test has improved. Error in interpretation of Western Blot testing carries no greater significance than error in interpretation of a chest x-ray of a patient with possible malignancy or tuberculosis. CMDs chose a Reference Service of 71020 Radiologic examination, chest, two views, frontal and lateral (RV=0.22), with a Harvard mean total time of 5 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Confirmation of a positive EIA assay for HIV using Western Blot with band identification, interpretation and report.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology - College of American Pathologists

Sample Size: 15/15 Response Rate (%): 100% Median RVW: 0.40

25th Percentile RVW: 0.37 75th Percentile RVW: 0.50 Low: 0.10 High: 1.59

Median Pre-Service Time: 4.5 min. Median Intra-Service Time: 10 min.

25th Percentile Intra-Svc Time: 5 75th Percentile Intra-Svc Time: 15 Low: 1 High: 30

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	

CPT Code: 84182-26

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
2)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
84182	4.5	10	5	4	3	3
80500	10	15	10	3	3	3
85060	2.5	15	4.5	3	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Western Blot with immunological probe for band identification is used to detect the antigens specific for a particular organism in a mixture of proteins, eg., from body cavity exudate. Typically such an exudate containing microbial antigen proteins is electrophoresed on a strip to separate the individual protein species. The strip is then blotted against a material containing an individual specific probe antibody, ie., antibodies each known to react with specific antigens in a particular microbial agent. Antibodies specific for individual proteins in the original mixture will form immune complexes and precipitate at the location of the electrophoresed protein component. Excess, non-precipitated protein is washed away and the strip stained to reveal specific bands of precipitate. These bands are given numbers corresponding to their molecular weight, eg., 35 kD.

The interpreting physician reviews the bands to discern the proteins of specific molecular weights that are associated with specific pathogenic micro-organisms. Differentiation of non-specific reactions from specific reactions is required and consideration of the likelihood of a particular pathogen being present in a certain anatomical location, in relation to the patient's clinical status. This requires discrimination between non-specific microbial antigens and ones that can be considered specific evidence of a particular infectious organism. Studies for different organisms are markedly different.

The CMDs statement that interpretation of Western Blot testing has become easier as the quality and technique of the test has improved is incorrect. As with the 88181 Western Blot interpretation, this service is a dynamic challenge with constant changes as new knowledge is gained and information about new organisms is defined. Physician work involved is at least as demanding as previously.

More than half of the survey respondents indicated that the work of performing this service has changed in the last five years, with those respondents indicating that patients are now more complex. They were split on whether the service is new technology that has become more familiar. Sixty-five percent of respondents agreed that the survey vignette describes their typical patient.

The current value of 0.37 for this interpretation was assigned by HCFA based on the value of the general clinical pathology consultation code 80500. The 84182 was not studied by Harvard or otherwise surveyed until now. The survey data from Harvard on the 80500 showed mean total times of 11-13 minutes, somewhat lower than the current survey total time of 19.5 minutes for the 84182. This survey time significantly exceeds the times for the two reference services chosen by the CMDs. Survey respondents chose the 80500 clinical pathology consultation and the 85060 peripheral blood smear interpretation as reference services, with physician work values of 0.37 and 0.45, respectively, and assigned the 88182 a median value of 0.40.

The College of American Pathologists recommends a physician work relative value of 0.40 for the 84182, Western Blot interpretation with immunological probe, based on the survey median and comparison to reference services.

CMD Comments

06-Jul-95

Code: 84182

1995 RVUs: 0.37

Recommended RVUs: 0.16

Ratio: -0.57

Long Descriptor: Protein; Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each

Reference Set (y/n): N Global Period: XXX Frequency: 1,993 Impact: -418.53

Source: 7 Year: 94 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
84182			
	71020 CHEST X-RAY	0.22	XXX

CMD Comment:

This is another method of performing a Western Blot test and the rationale for reduction in the RVUs is the same as for 84181.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
84182	48.9	17	6.4	51.1	6.4	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
84182		2064	

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
84182		0.5	

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
84182		
	general/family practice	3.5
	other nonphysician prov	93

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
84182			
	088	3.2	OTHER ARTHROPOD-BORNE DISEASES

CMD Comments

06-Jul-95

197	3.7	SECONDARY MALIGNANT NEOPLASM OF RESPIRATORY AND DIGESTIVE SYSTEMS
198	5.3	SECONDARY MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES
203	1.1	MULTIPLE MYELOMA AND IMMUNOPROLIFERATIVE NEOPLASMS
356	8	HEREDITARY AND IDIOPATHIC PERIPHERAL NEUROPATHY
357	9	INFLAMMATORY AND TOXIC NEUROPATHY
780	1.1	GENERAL SYMPTOMS
V72	3.2	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
84182							
CMD			XXX		0.00		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
84182								
CMD							0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
84182								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
84182									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
84182									
CMD				0.16	0.00				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 85390 Global Period: N/A Current RVW: 0.37 Recommended RVW: 1.20

CPT Descriptor:

Fibrinolysins or coagulopathy screen, interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs requested that the value be reduced to 0.16 on the basis that interpretation of a fibrinolysin screen requires less time and expertise than interpretation of a PA and lateral chest x-ray (71020) and a level 2 office visit (99212). Note: the current relative value of the 71020 is 0.22 and the Harvard time is 5 minutes. The value of the 99212 is 0.38 and the CPT time is 10 minutes face-to-face.

The American Society of Hematology requested that the value be increased to 1.19 and chose as a Reference Service the 88331 Pathology consultation during surgery; with frozen section(s), single specimen. The 88331 has a relative value of 1.19; Harvard mean total times for these vignettes were 20-24 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Evaluation and report of fibrinolysin screening panel in a 40 year old male with massive diffuse post operative bleeding.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology & Hematology; Joint Recommendation of the American Society of Hematology and the College of American Pathologists

Sample Size: 38/60 Response Rate (%): 63% Median RVW: 1.20

25th Percentile RVW: 0.62 75th Percentile RVW: 1.50 Low: 0.37 High: 2.57

Median Pre-Service Time: 8 min. Median Intra-Service Time: 16.5 min.

25th Percentile Intra-Svc Time: 10 min. 75th Percentile Intra-Svc Time: 40 min. Low: 3 min. High: 60

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>10 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	

CPT Code: 85390

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	88305	Level IV Surgical pathology, gross and microscopic examination	0.75
2)	88331	Pathology consultation during surgery; with frozen section(s), single specimen	1.19
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
85390	8	16.5	10	4	3	4
88305	3.5	23.5	5	4	3	3.5
88331	4	23	10	4	4	4

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The College of American Pathologists and American Society of Hematology used the same vignette and descriptions of pre-, intra- and post-service work to survey for this service and produced a combined recommendation of 1.20, the median RWV. The current value of 0.37 was assigned by HCFA based on comparison to the general code for clinical laboratory consultations, 80500. The 85390 was not studied by Harvard or otherwise surveyed. The survey data from Harvard on the 80500 showed mean total times of 11-13 minutes, lower than the current survey data on the 85390. Although the 80500 was not chosen as a reference service by those responding to the 85390 survey, others reporting estimates on the 80500 on other surveys of clinical laboratory test interpretations rate it lower in time and work than the ratings given for the 85390 on this survey.

Similarly, the reference services chosen by the CMDs have lower times and relative values than is appropriate for the fibrinolysins/coagulopathy screen. The radiology reference service Harvard time of 5 minutes total and the level 2 office visit time of 10 minutes face-to-face are both lower than the median survey time for the 85390 of 34.5 minutes total. In light of these data the recommendation of the CMDs is difficult to understand and we suspect they are not familiar with the service.

The evaluation of laboratory data in patients with coagulopathies is performed by physicians dealing with critical patient conditions. The physician will frequently be presented with data from several different areas of laboratory testing including coagulation and hematology. The data are reviewed in the historical context of the patient's previous laboratory parameters, often utilizing the clinical laboratory's computer information system and clinical data available to the interpreting physician through the computer's clinical diagnosis and patient demographics section. Other areas that may be part of the interpretation include evaluation of test control data and other variables of a technical nature to ensure the validity of the particular patient's test data and consultation with technical laboratory staff. A presumptive or differential diagnosis will then be provided with recommendations for additional testing as necessary to complete the diagnosis. This more sophisticated approach to clinical laboratory interpretation than technology previously allowed, although more time-consuming and mentally demanding for the physician, makes the service a much more comprehensive and valuable one than previously provided.

In the more critical situations, direct consultation with the clinician may be required in addition to the written narrative report. The amount of physician work involved in the 85390 is considerably higher than that provided in the typical 80500 to which the current 85390 relative value is indexed and certainly greater than the 0.16 value requested by the CMDs.

Sixty-three percent of survey respondents indicated that the work of performing this service has changed in the past 5 years, agreed that the service does not represent technology that has become more familiar and said that patients requiring the service are now more complex. The usual site of service has not changed. Ninety-two percent of respondents said the vignette described their typical patient.

The American Society of Hematology and College of American Pathologists recommend a physician work relative value of 1.20 based on the increase in physician work for the service, the median survey data and comparison to other available data.

CMD Comments

06-Jul-95

Code: 85390

1995 RVUs: 0.37

Recommended RVUs: 0.16

Ratio: -0.57

Long Descriptor: Fibrinolysis or coagulopathy screen, interpretation and report

Reference Set (y/n): N

Global Period: XXX

Frequency: 6,934

Impact: -1456.14

Source: 2

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
85390			
	71020 CHEST X-RAY	0.22	XXX
	99212 OFFICE/OUTPATIENT VISIT, EST	0.38	XXX

CMD Comment:

Interpretation of a fibrinolysis screen requires less time and expertise than the interpretation of a PA and lateral chest X-ray and a level 2 office visit.

Societies Wishing to Survey: ASH, CAP

Societies Wishing to Comment: ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
85390	41.8	11.3	17.1	44.8	13.4	0	3.6	4.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
85390	3848	8208	46

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
85390	74	68.4	-2.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
85390		
	group practices	8.6
	internal medicine	8.8
	other nonphysician prov	6.5
	pathology	69
	rheumatology	5.3

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

	ICD9	Pct of Time Used	ICD9 Descriptor
85390			
	041	1.2	BACTERIAL INFECTION IN CONDITIONS CLASSIFIED ELSEWHERE AND OF UNSPECIFIED SITE
	285	1.2	OTHER AND UNSPECIFIED ANEMIAS
	286	2.1	COAGULATION DEFECTS
	414	3.2	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
	428	2.1	HEART FAILURE
	434	1.2	OCCCLUSION OF CEREBRAL ARTERIES
	780	1.3	GENERAL SYMPTOMS
	V72	8.9	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
85390								
	ASH	26		XXX	.	0.37	.	0.37
	CMD	26		XXX	.	0.37	.	0.37

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
85390									
	ASH	0.37	0.37	.	1.00	1.00	1.00	1.19	336
	CMD	0.37	0.37	.	1.00	1.00	1.00	0.16	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
85390									
	ASH	XXX	.	.	.	.	.	.	.
	CMD	XXX	.	.	.	.	.	.	.

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
85390										
	ASH	.	.	.	.	.	.	.	.	.
	CMD	.	.	.	.	.	.	.	.	.

Harvard Data:

CMD Comments

06-Jul-95

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
85390									
ASH		.		1.19	0.37				
CMD		.		0.16	0.37				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 85576 Global Period: N/A Current RVW: 0.37 Recommended RVW: 0.50

CPT Descriptor:

Platelet; aggregation (in vitro) each agent—interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.16 on the basis that interpretation of platelet aggregation requires less time and expertise than interpretation of a PA and lateral chest x-ray and a level 2 office visit. The current relative value of the 71020 PA and lateral x-ray is 0.22 with a Harvard mean total time of 5 minutes. The level 2 office visit has a current value of 0.38 and a CPT time of 10 minutes face-to-face.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Evaluation and report of platelet aggregation profile and related laboratory data from a 69 year old man admitted for transurethral resection (TUR) with abnormal preoperative bleeding time.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 15/21 Response Rate (%): 71% Median RVW: 0.50

25th Percentile RVW: 0.34 75th Percentile RVW: 0.71 Low: 0.25 High: 2.00

Median Pre-Service Time: 5 min. Median Intra-Service Time: 7.5 min.

25th Percentile Intra-Svc Time: 4 min. 75th Percentile Intra-Svc Time: 12 min. Low: 2 High: 30 min.

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 6 min.

ICU: N/A

Other Hospital: N/A

Office: N/A

CPT Code: 85576

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
2)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
85576	5	7.5	6	3	3	3
80500	5	3	4	3	2	3
85060	5	10	7	4	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

In the platelet aggregation procedure the ability of platelets to aggregate (or be inhibited from aggregation) is measured by a continuous recording device. The result of the test is a family of curves depicting the patient's response to a number of specific agents at varying concentrations from which disorders of platelet function can be diagnosed and specific measures can be recommended to prevent future problems.

The interpreting physician must have a knowledge of the testing methodologies employed, the specific agents studied, and their actions on platelets and ability to interact with one another. Frequently, a number of concentrations are run for each agent studied, leading to an interpretation that has both qualitative and quantitative aspects. Since the test is relatively time consuming and infrequently performed, the interpreting physician often must review the test controls related to each agent and compare the results to the test patient to ensure validity.

The current value of 0.37 for this interpretation was assigned by HCFA based on the value of the general clinical pathology consultation code 80500. The 85576 was not studied by Harvard or otherwise surveyed until now. The survey data from Harvard on the 80500 showed mean total times of 11-13 minutes, lower than the current survey total time of 18.5 minutes for the 85576. Survey respondents rated the 85576 between the 80500 and the 85060 in terms of time and complexity. The survey time significantly exceeds the times for the two reference services chosen by the CMDs.

About one-third of survey respondents indicated that the work involved in platelet aggregation interpretation has increased in the last five years because the patients requiring the service are more complex. Survey respondents agreed that the survey vignette describes their typical patient.

The College of American Pathologists recommends a physician work relative value of 0.50 for the Platelet aggregation interpretation, based on the survey median and comparison to reference services.

E:\USER\JAC\SURVEY95\SUM85576

CMD Comments

06-Jul-95

Code: 85576

1995 RVUs: 0.37

Recommended RVUs: 0.16

Ratio: -0.57

Long Descriptor: Platelet; aggregation (in vitro), each agent

Reference Set (y/n): N

Global Period: XXX

Frequency: 24,158

Impact: -5073.18

Source: 11

Year: 94

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
85576			
	71020 CHEST X-RAY	0.22	XXX
	99212 OFFICE/OUTPATIENT VISIT, EST	0.38	XXX

CMD Comment:

Interpretation of platelet aggregation requires less time and expertise than the interpretation of a PA and lateral chest X-ray and a level 2 office visit.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
85576	40.5	2.9	1.3	34.8	4.5	0	2	64.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
85576	12939	23990	36.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
85576	8.5	3.2	-2.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
85576		
	general/family practice	14.5
	hematology/oncology	2.2
	internal medicine	3.3
	other nonphysician prov	72.1
	pathology	5.4

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
85576		
251	2.7	OTHER DISORDERS OF PANCREATIC INTERNAL SECRETION
285	1.3	OTHER AND UNSPECIFIED ANEMIAS
286	5.5	COAGULATION DEFECTS
434	1.3	OCCCLUSION OF CEREBRAL ARTERIES

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
85576							
CMD	26		XXX		0.37		0.37

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
85576								
CMD	0.37	0.37		1.00	1.00	1.00	0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
85576								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
85576									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
85576									
CMD				0.16	0.37				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 86077 Global Period: N/A Recommended RVW: 0.99

Current RVW: 0.37

Source and Summary of Comment to HCFA on this Service: The American Society of Hematology requested the work relative values be increased to 0.94 in our comments to the Health Care Financing Administration, February 6, 1995. CPT 86078 -- Physician blood bank service, investigation of transfusion reaction including suspicion of transmissible disease, was chosen as the reference service which has a work relative value of 0.94. Harvard mean total time for the reference is 37 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Evaluation of a positive red cell antibody screen performed on a preoperative blood sample and preparation of a report recommending the procedure(s) to identify compatible blood for a transfusion.

Description of Pre-Service Work: Includes work from the time the service is begun and may include obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to the actual performance of the evaluation.

Description of Intra-Service Work: Evaluation and interpretation of the screen, review of serological results, comparison to previous serology reports; any review of literature during examination of test results; determination of clinical significance or serologic findings; selection of appropriate blood components; clinical determination of urgency of transfusion; assessment of potential risks and benefits of transfusion; determination of best cross match technique; clinical monitoring for adverse effects; and any dictation or report preparation performed during the examination of the test results.

Description of Post-Service Work: Includes report preparation and finalization; written and telephone communications with other professionals, patients and families; obtaining and reviewing the results of other diagnostic studies, including examination of previous reports, after examination of the test results; arranging for future studies or services.

SURVEY DATA:

Specialty: American Society of Hematology

Sample Size: 50 / 10 Response Rate (%): 20% Median RVW: 0.99
 25th Percentile RVW: 0.94 75th Percentile RVW: 1.14 Low: 0.45 Hgt: 1.59

Median Pre-Service Time: N/A Median Intra-Service Time: 40

25th Percentile Intra-Service Time: 30 75th Percentile Intra-Service Time: 45

Low Intra-Service Time: 20 High Intra-Service Time: 69

Median Post Service Time: Total Time Number of Visits

Day of Procedure N/A N/A

ICU: N/A N/A

Other Hospital ✓ N/A N/A

Office N/A N/A

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1.)	86078	Physician blood bank service, investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report.	0.94

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre, intra, and post-service time and intensity (mental effort and judgement; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference service listed above.

CPT Code	Pre	Intra	Post	Mental	Technical	Psychological
86078	N/A	37	N/A	4	3	3
86077	N/A	40	N/A	4	3	3

RATIONALE

The American Society of Hematology believes the survey results adequately indicate that a work RVU of 0.99 is justified. Currently, CPT 86077 is assigned 0.37 work RVUs. This code was

not included in the Harvard study, or otherwise surveyed. The survey data from Harvard on the reference service, CPT 80678 -- Physician blood bank service, investigation of transfusion reaction including suspicion of transmissible disease, showed a mean total time of 37 minutes, slightly lower than the current survey data on CPT 86077 at 40 minutes. CPT 86078 is assigned 0.94 work RVUs.

Conclusion: The American Society of Hematology recommends a physician work relative value of 0.99 for CPT 86077 based upon the increase in physician work for this service, the median survey data and comparison to the other available data. ASH believes the current RVW of 0.37 is undervalued. Though ASH did not receive a large return on the survey since this is a low volume service for hematologists (Medicare was only billed 3 times in 1993 for this service by a hematologist); we believe the interest of ASIM, CAP and ASCP in commenting on CPT 86077 amplifies the survey results in favor of an increase.

Has the work in this service changed in the past 5 years? 1 Yes 6 No. If yes, complete a -
c:

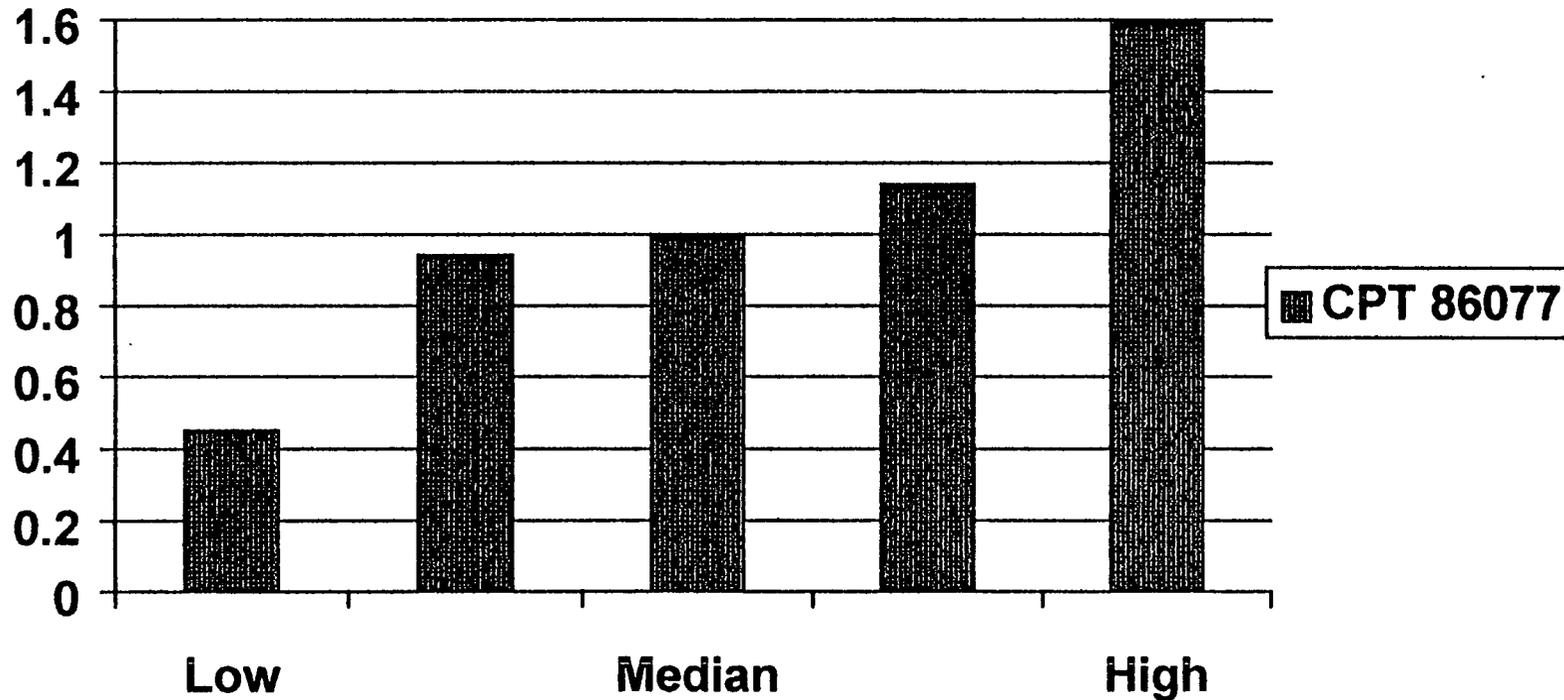
a: This service represents a new technology that has become more familiar (i.e. less work). 1
I agree 3 I do not agree.

b: Patients requiring this service are now 3 more complex (more work) _____ less complex
(less work) 1 no change

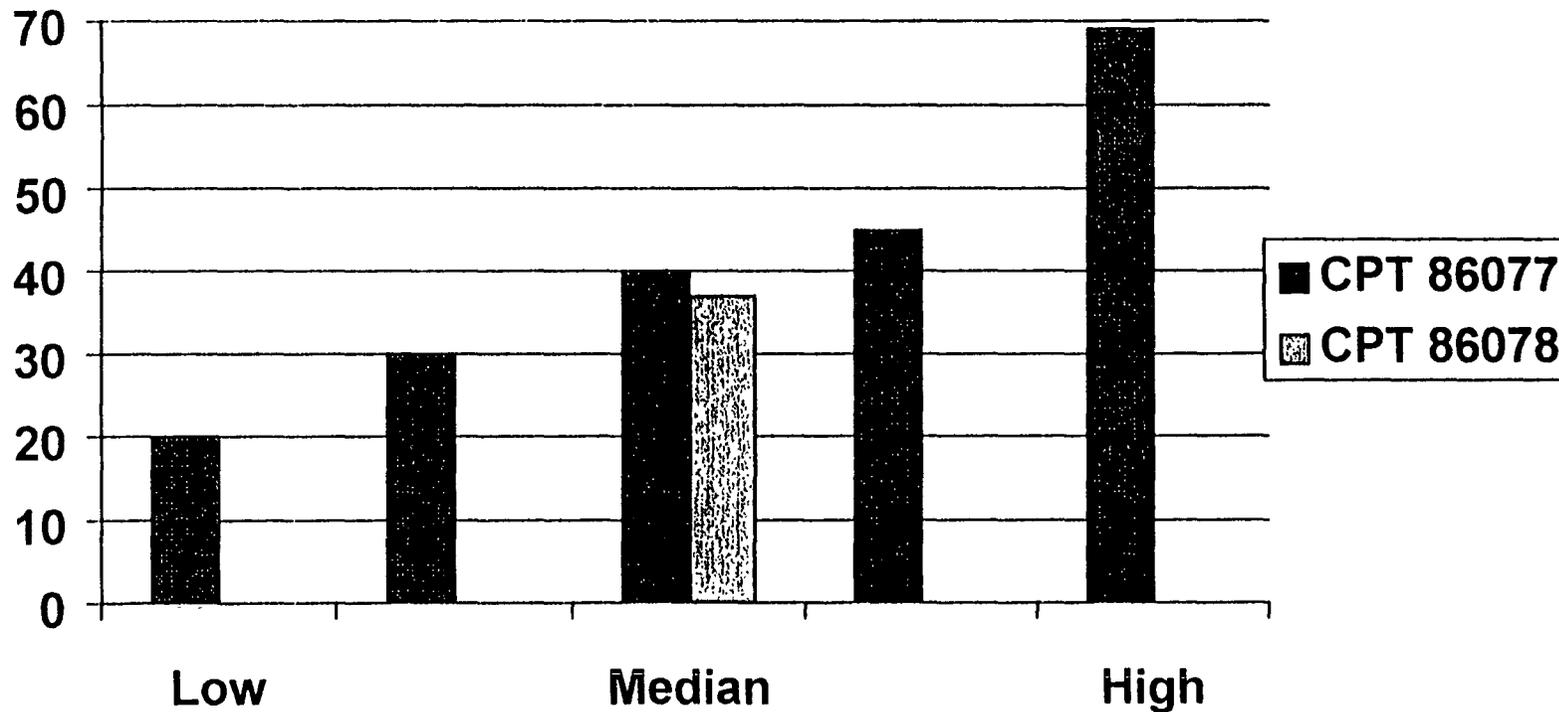
c: The usual site-of-service has changed ____ from outpatient to inpatient ____ from inpatient
to outpatient 4 no change.

Do you agree that the typical service/patient provided above describes your typical patient 10 yes
____no

WORK RVW ESTIMATES FOR CPT 86077 -- PHYSICIAN BLOOD
BANK SERVICE, DIFFICULT CROSS MATCH AND/OR
EVALUATION OF IRREGULAR ANTIBODY(S), INTERPRETATION
AND WRITTEN REPORT



TOTAL TIME ESTIMATES IN MINUTES FOR CPT 86077 --
PHYSICIAN BLOOD BANK SERVICE, DIFFICULT CROSS MATCH
AND/OR EVALUATION OF IRREGULAR ANTIBODY(S),
INTERPRETATION AND WRITTEN REPORT



Public Comments

06-Jul-95

Code: 86077

1995 RVUs: 0.37

Recommended RVUs: 0.94

Ratio:

Long Descriptor: Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report

Reference Set (y/n): N Global Period: XXX Frequency: 14,114 Impact: 8045

Source: 2 Year: 92 Public Comment Letter: 336

Reference Services:

CMD Comment:

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Societies Wishing to Survey: ASH

Societies Wishing to Comment: ASCP, ASIM, CAP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
86077	42.1	11.9	22.2	65.4	8.7	4.8	8	7.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
86077	16582	15819	-2.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
86077	75.9	74.4	-0.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
86077	group practices	4.4
	hematology/oncology	3.7
	pathology	90

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
86077	285	1.6	OTHER AND UNSPECIFIED ANEMIAS
	411	1.2	OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE

Public Comments

06-Jul-95

999	2.7	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSI- FIED
V72	9.6	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
86077							
ASH			XXX		0.37		0.37

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
86077								
ASH	0.37	0.37		1.00	1.00	1.00	0.94	336

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
86077								
ASH	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
86077									
ASH									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
86077									
ASH				0.94	0.37				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 86079 Global Period: N/A Recommended RVW: 0.94

Current RVW: 0.37

Source and Summary of Comment to HCFA on this Service: The American Society of Hematology requested the work relative value be increased to 0.94 in our comments to the Health Care Financing Administration, February 6, 1995. CPT 86078 -- Physician blood bank service, investigation of transfusion reaction including suspicion of transmissible disease, was chosen as the reference service which has a work relative value of 0.94. Harvard mean total time for the reference is 37 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Evaluation of a 40 year old man whose last whole blood donation was less than 56 days ago and preparation of a report accepting him as "dedicated directed" blood donor for his son.

Description of Pre-Service Work: Includes work from the time the service is begun and may include obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to the actual performance of the evaluation.

Description of Intra-Service Work: Clinical assessment of the urgency of the transfusion; selection of appropriate cross match or other laboratory procedures; selection of appropriate blood components; any review of literature or research during the examination of test results; determination of potential risks and benefits of transfusion (or product donation) in order to make transfusion therapy recommendations; clinical monitoring of the recipient or donor for adverse effects of the transfusion or donation, including reassessment of decision based upon changing clinical status; and any dictation or report preparation performed during the examination of the test results.

Description of Post-Service Work: Includes report preparation and finalization; written and telephone communications with other professionals, patients and families; obtaining and reviewing the results of other diagnostic studies, including examination of previous reports, after examination of the test results; arranging for future studies or services.

SURVEY DATA:

Specialty: American Society of Hematology

Sample Size: 50 / 9 Response Rate (%): 19% Median RVW: 0.94
 25th Percentile RVW: 0.90 75th Percentile RVW: 0.99 Low: 0.60 High 1.14
 Median Pre-Service Time: N/A Median Intra-Service Time: 30
 25th Percentile Intra-Service Time: 30 75th Percentile Intra-Service Time: 40
 Low Intra-Service Time: 15 High Intra-Service Time: 45
 Median Post Service Time: Total Time Number of Visits
 Day of Procedure N/A N/A
 ICU: N/A N/A
 Other Hospital ✓ N/A N/A
 Office N/A N/A

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1.)	86078	Physician blood bank service, investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report.	0.94

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre, intra, and post-service time and intensity (mental effort and judgement; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference service listed above.

CPT Code	Pre	Intra	Post	Mental	Technical	Psychological
86078	N/A	37	N/A	4	3	3
86079	N/A	30	N/A	4	3	4

RATIONALE

The American Society of Hematology believes the survey results adequately indicate that a work

RVU equal to that of the reference service of 0.94 is justified. Currently, CPT 86079 is assigned 0.37 work RVUs. This code was not included in the Harvard study, or otherwise surveyed. The survey data from Harvard on the reference service, CPT 80678 -- Physician blood bank service, investigation of transfusion reaction including suspicion of transmissible disease, showed a mean total time of 37 minutes, only slightly higher than the current survey data on CPT 86079 at 30 minutes.

Conclusion: The American Society of Hematology recommends a physician work relative value of 0.94 for CPT 86079 based upon the increase in physician work for this service, the median survey data and comparison to the other available data. ASH believes the current RVW of 0.37 is undervalued. ASH did not receive a large return on the survey since this is a low volume service for hematologists (Medicare was only billed 5 times in 1993 for this service by a hematologist). Despite the low survey response, we believe the RUC should still consider a change in the value and obtain the views of ASIM, CAP and ASCP who expressed interest in commenting on CPT 86079.

Has the work in this service changed in the past 5 years? 1 Yes 6 No. If yes, complete a -
c:

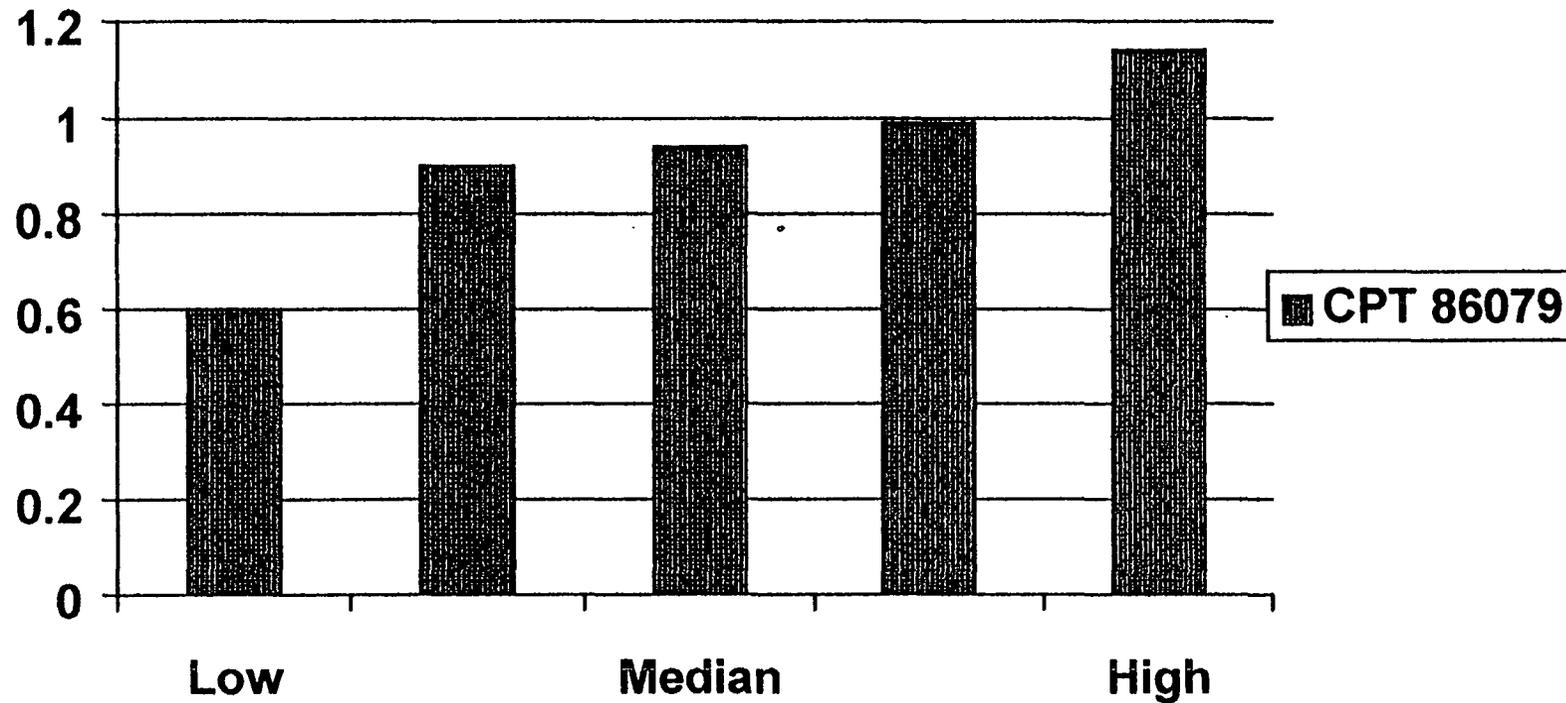
a: This service represents a new technology that has become more familiar (i.e. less work). 1
I agree 3 I do not agree.

b: Patients requiring this service are now _____ more complex (more work) _____ less complex
(less work) _____ no change

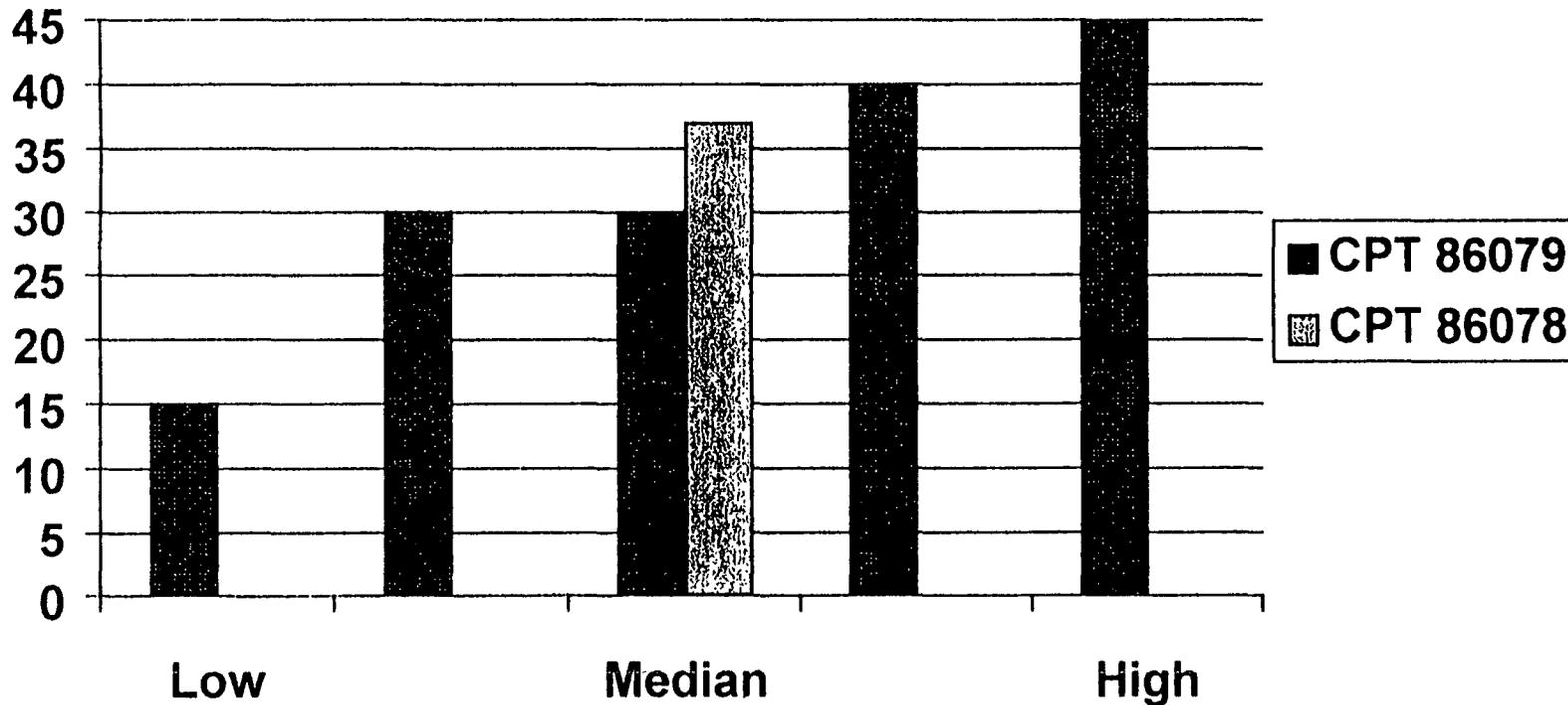
c: The usual site-of-service has changed _____ from outpatient to inpatient _____ from inpatient
to outpatient _____ no change.

Do you agree that the typical service/patient provided above describes your typical patient _____
yes _____no

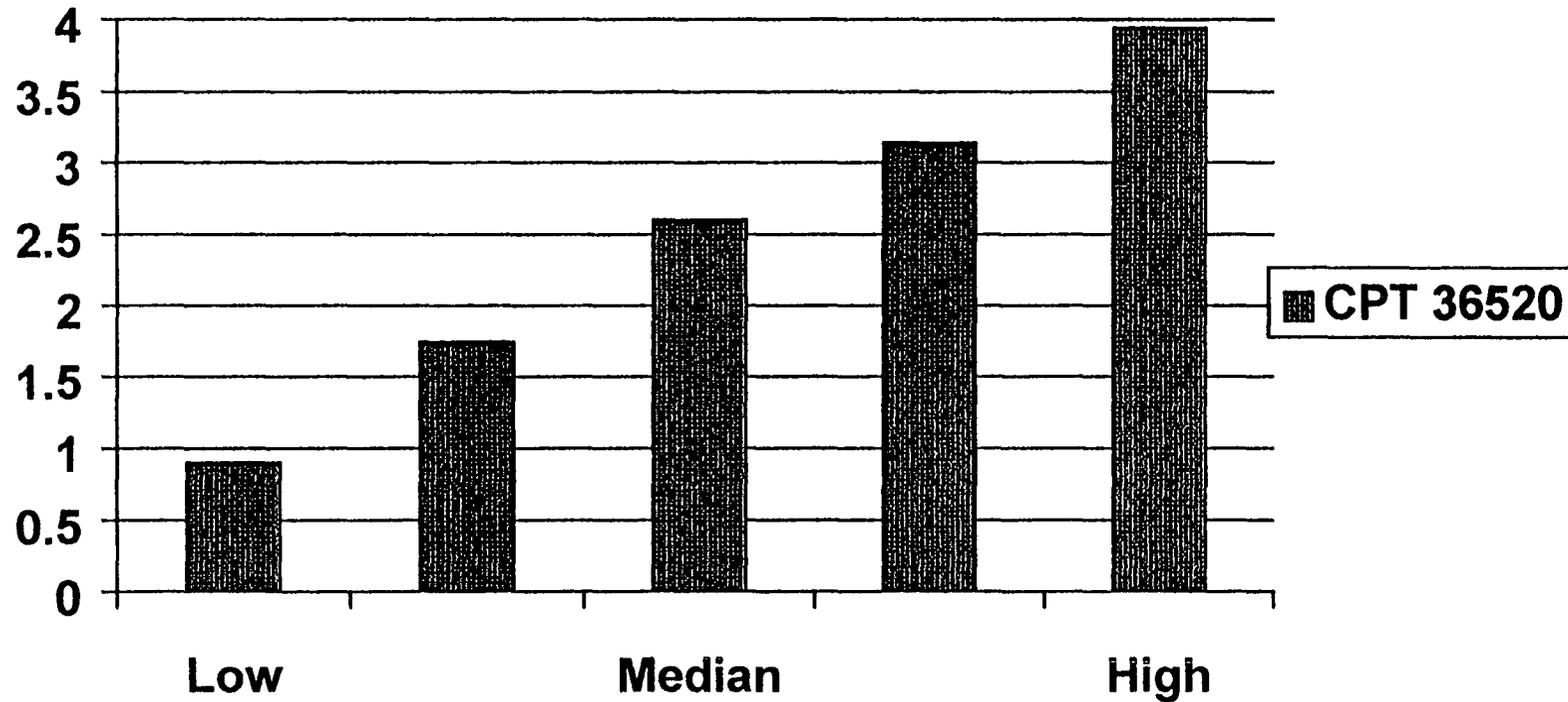
WORK RVW ESTIMATES FOR CPT 86079 -- PHYSICIAN BLOOD BANK SERVICE, AUTHORIZATION FOR DEVIATION FROM STANDARD BLOOD BANK PROCEDURES WITH WRITTEN REPORT



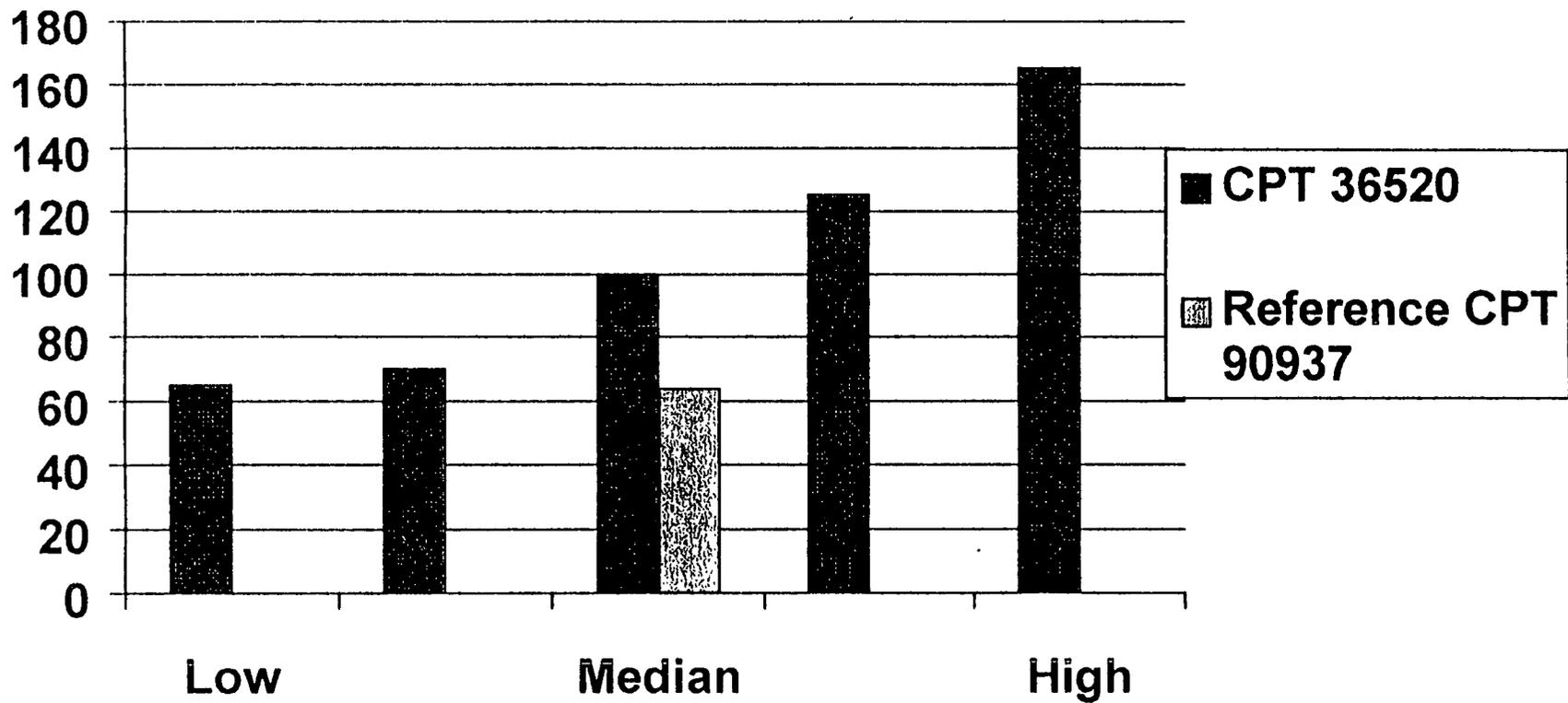
TOTAL TIME ESTIMATES IN MINUTES FOR CPT 86079 --
PHYSICIAN BLOOD BANK SERVICE, AUTHORIZATION FOR
DEVIATION FROM STANDARD BLOOD BANK PROCEDURES
WITH WRITTEN REPORT



WORK RVW ESTIMATES FOR CPT 36520
THERAPEUTIC APHERESIS PLASMA AND/OR CELL EXCHANGE



TOTAL TIME ESTIMATES IN MINUTES FOR CPT 36520
THERAPEUTIC APHERESIS PLASMA AND/OR CELL EXCHANGE



Public Comments

06-Jul-95

Code: 86079

1995 RVUs: 0.37

Recommended RVUs: 0.94

Ratio:

Long Descriptor: Blood bank physician services; authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report

Reference Set (y/n): N Global Period: XXX Frequency: 1,012 Impact: 577

Source: 2 Year: 92 Public Comment Letter: 336

Reference Services:

CMD Comment:

Societies Wishing to Survey: ASH

Societies Wishing to Comment: ASCP, ASIM, CAP

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
86079	53.6	25	11.5	67.9	3.6	0	0	10.7

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
86079	1729	1116	-19.7

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
86079	55.3	72.4	8.5

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
86079	other nonphysician prov	8.2
	pathology	89.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
86079	250	1.8	DIABETES MELLITUS
	276	1.8	DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE
	285	1.8	OTHER AND UNSPECIFIED ANEMIAS

Public Comments

06-Jul-95

286	1.8	COAGULATION DEFECTS
414	2.7	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
424	2.7	OTHER DISEASES OF ENDOCARDIUM
799	2.7	OTHER ILL-DEFINED AND UNKNOWN CAUSES OF MORBIDITY AND MORTALITY
V72	8.9	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
86079							
ASH			XXX		0.37		0.37

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
86079								
ASH	0.37	0.37		1.00	1.00	1.00	0.94	336

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itme	Notett	Imppt
86079								
ASH	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
86079									
ASH									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
86079									
ASH				0.94	0.37				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 86255 Global Period: N/A Current RVW: 0.37 Recommended RVW: 0.40

CPT Descriptor:

Fluorescent antibody; screen, each antibody -- interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.16 on the basis that interpretation of fluorescent antibody screen, each antibody, requires less time and expertise than interpretation of a PA and lateral chest x-ray. Furthermore, since this is for "each antibody" and screens are done usually for 3 antibodies, the total relative value of 0.37 (1.11) is excessive. The 71020 PA and Lateral chest x-ray is currently valued at 0.22 and has a Harvard total time of 5 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Evaluation and report of immunofluorescence antibody screen study in a patient suspected of having Systemic Lupus Erythematosus (SLE).

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 31/50 Response Rate (%): 62% Median RVW: 0.40

25th Percentile RVW: 0.26 75th Percentile RVW: 0.45 Low: 0.13 High: 1.00

Median Pre-Service Time: 3 min. Median Intra-Service Time: 5 min.

25th Percentile Intra-Svc Time: 3 min. 75th Percentile Intra-Svc Time: 10 min. Low: 1 High: 20 min.

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	
		CPT Code: <u>86255</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
2)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
86255	3	5	5	4	3	2
80500	5	5	6	3	2.5	3
85060	4	12	4	3.5	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Fluorescent antibody screen is used for detection and quantitation of autoantibodies to various cell constituents, eg., anti-mitochondria or anti-nuclear antigen (ANA). A thin layer of cells from either a cell culture or animal tissue is placed on a slide, patient serum is diluted and added, the slide is incubated, and non-adhering protein is washed off. Then a fluorescent-tagged animal antibody to human IgG (eg., FI-rabbit-anti-human IgG) is added and after a suitable period the unbound FI-tagged antiserum is washed away. The slide is then examined by the interpreting physician with a fluorescent microscope and the nature of the organelles showing fluorescence are identified.

Interpretation of the prepared slide requires extensive knowledge of the procedure and its limitations and a very comprehensive knowledge of the anatomy of the tissue/cells being examined. Using a fluorescent microscope the interpreting physician examines the fluorescent stain of animal tissues making a determination as to whether the cells fluoresce positively, which part of the cell is adsorbing antibody, and regarding the pattern of fluorescence. The interpreting physician must always be aware of the potential for artifacts of both the system (reagents, tissue, equipment) and of the patient. A disease or unexpected immunity within the test subject could contribute to a false negative or a false positive result and the interpreting physician must always be on guard for such situations. For example, a patient with an immunologic sensitivity to bovine protein, eg., bovine serum albumin (BSA), might show an extraordinary response to an attempt to examine serum for autoantibody using tissue culture cells grown in the presence of BSA.

The CMDs' statement that, since screens are usually done for 3 antibodies, the total of 3 times 0.37 (or 1.11) is excessive is inappropriate. The study of each auto-antibody is essentially a study unto itself since different tissues/cells are used to demonstrate reactions for different antibodies--there is little if any economy in physician work if multiple antibodies are examined.

The current value for the fluorescent antibody screen interpretation was assigned by HCFA based on the value of 0.37 for the general clinical pathology consultation code 80500. The 86255 was not studied by Harvard and has not been surveyed until now. The current survey mean total time for the 86255 is 13 minutes, above that for the CMDs' reference service. Survey respondents rated the 86255 slightly more complex than the 80500, but slightly less complex and requiring less time than the 85060 peripheral blood smear interpretation that has a current value of 0.45.

Survey respondents said that the work has not changed in the last five years and that the survey vignette does describe their typical patient.

The College of American Pathologists recommends a physician work value of 0.40 for the fluorescent antibody screen interpretation, based on the median survey value and comparison to reference services.

CMD Comments

06-Jul-95

Code: 86255

1995 RVUs: 0.37

Recommended RVUs: 0.16

Ratio: -0.57

Long Descriptor: Fluorescent antibody, screen, each antibody

Reference Set (y/n): N Global Period: XXX Frequency: 254,510 Impact: -53447.1

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
86255			
	71020 CHEST X-RAY	0.22	XXX

CMD Comment:

Interpretation of florescent antibody screen, each antibody requires less time and expertise than the interpretation of a PA and lateral chest X-ray. Furthermore, since this is for "each antibody" and screens are done usually for 3 antibodies, the total RVUs of 0.37 times 3 (1.11) is excessive.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
86255	41.6	7.8	12.1	71.8	11.1	0.6	0.6	3.1

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
86255	319214	264296	-9

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
86255	2.6	4	0.7

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
86255		
	group practices	2.1
	other nonphysician prov	83.3
	pathology	6.6
	rheumatology	4.7

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
86255		
401	1.2	ESSENTIAL HYPERTENSION
714	1.2	RHEUMATOID ARTHRITIS AND OTHER INFLAMMATORY POLYARTHROPATHIES
716	1.4	OTHER AND UNSPECIFIED ARTHROPATHIES
V72	9.1	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
86255							
CMD	26		XXX		0.37		0.37

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
86255								
CMD	0.37	0.37		1.00	1.00	1.00	0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
86255								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
86255									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
86255									
CMD				0.16	0.37				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 86256 Global Period: NA Current RVW: 0.37 Recommended RVW: 0.39

CPT Descriptor:

Fluorescent antibody; titer, each antibody-interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.16 on the basis that interpretation of fluorescent antibody titer, each antibody, requires less time and expertise than interpretation of a PA and lateral chest x-ray, CPT 71020, that is currently valued 0.22 and has a Harvard mean total time of 5 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Interpretation and report of immunofluorescent antibody titer study in a patient with possible Toxoplasmosis (eg, IgG).

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology - College of American Pathologists

Sample Size: 26/50 Response Rate (%): 52% Median RVW: 0.39

25th Percentile RVW: 0.22 75th Percentile RVW: 0.50 Low: 0.10 High: 0.90

Median Pre-Service Time: 3 min. Median Intra-Service Time: 5 min.

25th Percentile Intra-Svc Time: 3 75th Percentile Intra-Svc Time: 10 Low: 0.5 High: 20

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5</u>	
ICU:	<u>N/A</u>	<u> </u>
Other Hospital:	<u>N/A</u>	<u> </u>
Office:	<u>N/A</u>	<u> </u>

CPT Code: 86256

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
2)	N/A		
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
86256	3	5	5	3	3	2
85060	3	13.5	5	3.5	3	3

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Fluorescent antibody titer is used for detection and quantitation of autoantibodies to various cell constituents, eg., anti-mitochondria or anti-nuclear antigen (ANA). A thin layer of cells from either a cell culture or animal tissue is placed on a slide, patient serum is diluted and added, the slide is incubated, and non-adhering protein is washed off. Then a fluorescent-tagged animal antibody to human IgG (eg., Fl-rabbit-anti-human IgG) is added and after

a suitable period the unbound FI-tagged antiserum is washed away. The slide is then examined by the interpreting physician with a fluorescent microscope and the nature of the organelles showing fluorescence are identified.

The titer interpretation involves determination of the amount of auto-antibody present, a semi-quantitative determination made by the interpreting physician. As with the screen, the interpretation requires extensive knowledge of the procedure and its limitations and a very comprehensive knowledge of the anatomy of the tissue/cells being examined. The interpreting physician must review the results of the titer technical studies to be certain that the fluorescence seen is constant within the organelle so that only a single antibody is being studied. As with the screen, the determination of each titer is essentially an individual study since different tissues/cells are generally used to demonstrate reactions for different antibodies. It is not appropriate to link multiples together as one service or to discount work for multiple titers.

The current value for the fluorescent antibody titer interpretation was assigned by HCFA based on the value of 0.37 for the general clinical pathology consultation code 80500. The 86256 was not studied by Harvard and has not been surveyed until now. The current survey mean total time for the 86256 is 13 minutes, above that for the CMDs' reference service. Survey respondents rated the 86256 slightly less complex and requiring less time than the 85060 peripheral blood smear interpretation that has a current value of 0.45, and comparable in time and complexity to the 86255 fluorescent antibody screen.

The College of American Pathologists recommends a physician work value of 0.39 for the fluorescent antibody titer, based on median survey results and comparison to reference services.

E:\USER\JAC\SURVEY95\SUM86256

CMD Comments

06-Jul-95

Code: 86256 **1995 RVUs:** 0.37 **Recommended RVUs:** 0.16 **Ratio:** -0.57

Long Descriptor: Fluorescent antibody, titer, each antibody

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 169,055 **Impact:** -35501.55

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
86256			
	71020 CHEST X-RAY	0.22	XXX

CMD Comment:

The interpretation of fluorescent antibody titer, each antibody, requires less time and expertise than the interpretation of a PA and lateral chest X-ray.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis – Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
86256	39.7	7.3	12.1	70.4	11.8	0.7	0.9	4.6

Trends Analysis – Frequency:

	QX92	QX94	Chg92_94
86256	356477	196414	-25.8

Trends Analysis – Site of Service:

	Pct in 92	Pct in 94	Chg92_94
86256	1.9	4	1

Trends Analysis – Specialty Mix:

	Specialty	PCT_94
86256		
	other nonphysician prov	84
	pathology	6.3
	rheumatology	4.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
86256			
	401	1.2	ESSENTIAL HYPERTENSION

CMD Comments

06-Jul-95

710	1.2	DIFFUSE DISEASES OF CONNECTIVE TISSUE
714	1.4	RHEUMATOID ARTHRITIS AND OTHER INFLAMMATORY POLYARTHROPATHIES
715	1	OSTEOARTHROSIS AND ALLIED DISORDERS
716	1.2	OTHER AND UNSPECIFIED ARTHROPATHIES
V72	8.2	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
86256							
CMD	26		XXX	.	0.37	.	0.37

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
86256								
CMD	0.37	0.37	.	1.00	1.00	1.00	0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
86256								
CMD	XXX	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuis	Offvis
86256									
CMD

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
86256									
CMD	.	.	.	0.16	0.37	.	.	.	.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 86320 Global Period: N/A Current RVW: 0.37 Recommended RVW: 0

CPT Descriptor:

Immunoelectrophoresis; serum--interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.17 on the basis that interpretation of serum immunoelectrophoresis requires less time and expertise than interpretation of a PA and lateral chest x-ray; however, it requires slightly more expertise than interpretation of a serum electrophoresis (84165) which CMDs asked to be reduced to 0.16. The current relative value of the 71020 PA and lateral x-ray is 0.22 with a mean Harvard time of 5 minutes. The 86320 vignette described below was studied by Harvard, had a mean total time of 11 minutes, and has a current value of 0.37 on the basis of the Harvard data.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Evaluation and report of a serum immunoelectrophoresis study in a 59 year old male with monoclonal gammopathy.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 32/40 Response Rate (%): 80% Median RVW: 0.48

25th Percentile RVW: 0.37 75th Percentile RVW: 0.68 Low: 0.20 High: 2.22

Median Pre-Service Time: 4.5 min. Median Intra-Service Time: 9 min.

25th Percentile Intra-Svc Time: 5 min. 75th Percentile Intra-Svc Time: 15 min. Low: 0.6 min. High: 20 min.

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>3 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	

CPT Code: 86320

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
2)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
3)	84165*	Electrophoretic fractionation and quantitation	
4)	N/A		

* Selected by CMDs not survey respondents

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
86320	4.5	9	3	3	3	3
80500	5	10	5	3	2	2
85060	5	13.5	2	3	3	3
84165*	3	5	5	3	3	3

*Selected by CMDs not survey respondents

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Interpretation and report of a protein immunoelectrophoresis is a follow-up study in patients that have an existing proteinopathy. The interpreting physician reviews dispersed patterns of patient serum and compares them to controls looking at at least five such patterns. Interpretation requires a judgment as to whether the shape and density of the sample is sufficiently different from that of the control to establish an abnormality. With the more extensive use of clinical laboratory computers (laboratory information systems), additional data related to this proteinopathy can be evaluated with a more complete and useful clinical interpretation of the protein abnormality.

The median survey total time for the serum immunoelectrophoresis was 16.5 minutes, well above the total time for the radiology reference service chosen by the CMDs. Survey respondents chose the 80500 general clinical pathology consultation and the peripheral blood smear interpretation as reference services, gave those services somewhat higher times than the 86320, but rated the complexity of the service the same as the 85060 that has a work value of 0.45. The survey median for the 86320 is 0.48.

Survey respondents agreed that the work of performing this service has not changed in the past five years and that the survey vignette does describe their typical patient.

The College of American Pathologists recommends a physician work relative value of 0.48 for the serum immunoelectrophoresis interpretation based on the survey median and comparison to reference services.

CMD Comments

06-Jul-95

Code: 86320

1995 RVUs: 0.37

Recommended RVUs: 0.17

Ratio: -0.54

Long Descriptor: Immunoelectrophoresis; serum

Reference Set (y/n): N

Global Period: XXX

Frequency: 52,688

Impact: -10537.6

Source: 2

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
86320			
	71020 CHEST X-RAY	0.22	XXX
	84165 ASSAY SERUM PROTEINS	0.00	XXX

CMD Comment:

Interpretation of serum immunoelectrophoresis requires less time and expertise than the interpretation of a PA and lateral chest X-ray. However, interpretation of serum immunoelectrophoresis requires slightly more expertise than the interpretation of a serum electrophoresis (84165).

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
86320	51.6	9.8	12.8	56.8	5.6	0.2	1	4.8

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
86320	62179	59020	-2.6

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
86320	10.1	10.7	0.3

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
86320		
	group practices	4.7
	other nonphysician prov	74.5
	pathology	17.6

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
86320		
203	1.3	MULTIPLE MYELOMA AND IMMUNOPROLIFERATIVE NEOPLASMS
273	1.1	DISORDERS OF PLASMA PROTEIN METABOLISM
V72	8	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
86320							
CMD	26		XXX		0.37		0.37

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
86320								
CMD	0.37	0.37		1.00	1.00	1.00	0.17	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
86320								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
86320									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
86320									
CMD				0.17	0.37				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 86325 Global Period: N/A Current RVW: 0.37 Recommended RVW: 0.45

CPT Descriptor:

Immunoelectrophoresis; other fluids (eg, urine, CSF) with concentration—interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.17 on the basis that interpretation of immunoelectrophoresis of other fluids (urine, CSF) requires less time and expertise than interpretation of a PA and lateral chest x-ray. CMDs said the 86325 interpretation is similar to 86320 and requires slightly more expertise than the 84165 that they asked be reduced to 0.16. The current relative value of the 71020 PA and lateral x-ray is 0.22 with a Harvard time of 5 minutes. The 86320 vignette was studied by Harvard, had a mean total time of 11 minutes, and has a current value of 0.37 on the basis of the Harvard data.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Evaluation and report of urine immunoelectrophoresis study for the presence of Bence Jones proteins in a patient with suspected monoclonal gammopathy.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 33/33 Response Rate (%): 100% Median RVW: 0.45

25th Percentile RVW: 0.37 75th Percentile RVW: 0.58 Low: 0.20 High: 2.22

Median Pre-Service Time: 3 min. Median Intra-Service Time: 8 min.

25th Percentile Intra-Svc Time: 5 min. 75th Percentile Intra-Svc Time: 15 min. Low: 0.45 High: 20 m'

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>3 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	
		CPT Code: <u>86325</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
2)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
86325	3	8	3	3	3	2
80500	5	10	2	3	2.5	2.5
85060	5	12	0	3	3	2.5
84165*	3	5	5	3	3	3
86320*	4.5	9	3	3	3	3

*Selected by CMDs not survey respondents

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Interpretation of a urine protein immunoelectrophoresis is similar to that performed in a serum immunoelectrophoresis. It is a service provided to patients that are being followed for existing proteinopathy as a method of following their therapy. The interpreting physician reviews dispersed patterns of patient urine, compares them to controls looking at at least five such patterns, and correlates this information with findings of the serum immunoelectrophoresis or other such studies. Interpretation requires a judgment as to whether the shape and density of the sample is sufficiently different from that of the control to be abnormal. Use of laboratory information systems that allow access to additional data related to the proteinopathy make this a more complete and useful interpretation of the protein abnormality.

This service should be valued approximately the same as the 86320 serum immunoelectrophoresis; the CMDs apparently agree with that premise. The median survey total time for the 86325 immunoelectrophoresis is 14 minutes, well above the mean total time for the radiology reference service chosen by the CMDs and closer to the time for the 86320 and the 84165. Survey respondents chose the general clinical pathology consultation service (80500) and the peripheral blood smear interpretation as their reference services and rated the complexity of the 86325 similar to that of those services. The median survey value for the 86325 is 0.45, the same as the 85060 reference service.

Survey respondents indicated that the work of performing this service has not changed in the past five years and that the survey vignette describes their typical patient.

The College of American Pathologists recommends a physician work relative value of 0.45 for interpretation of immunoelectrophoresis of other (than serum) fluids based on the median survey value and comparison to reference services.

CMD Comments

06-Jul-95

Code: 86325

1995 RVUs: 0.37

Recommended RVUs: 0.17

Ratio: -0.54

Long Descriptor: Immunoelectrophoresis; other fluids (eg, urine, CSF) with concentration

Reference Set (y/n): N Global Period: XXX Frequency: 19,338 Impact: -3867.6

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
86325			
	71020 CHEST X-RAY	0.22	XXX
	84165 ASSAY SERUM PROTEINS	0.00	XXX
	86325 OTHER IMMUNOELECTROPHORESIS	0.00	XXX

CMD Comment:

The interpretation of immunoelectrophoresis of other fluids (urine, CSF) requires less time and expertise than the interpretation of a PA and lateral chest X-ray. This interpretation is similar to 86325 and requires slightly more expertise than the interpretation of 84165.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
86325	51.3	7.9	13.1	55.1	3.6	0.4	0.7	4.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
86325	23508	22186	-2.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
86325	9	14.7	2.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
86325		
	group practices	6.7
	other nonphysician prov	67.9
	pathology	23.1

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

	ICD9	Pct of Time Used	ICD9 Descriptor
86325	203	1.6	MULTIPLE MYELOMA AND IMMUNOPROLIFERATIVE NEOPLASMS DISORDERS OF PLASMA PROTEIN METABOLISM SPECIAL INVESTIGATIONS AND EXAMINATIONS
	273	1.2	
	V72	9.1	

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
86325							
CMD	26		XXX	.	0.37	.	0.37

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
86325								
CMD	0.37	0.37	.	1.00	1.00	1.00	0.17	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
86325								
CMD	XXX	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
86325									
CMD

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
86325									
CMD	.	.	.	0.17	0.37	.	.	.	.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 86327 Global Period: NA Current RVW: 0.37 Recommended RVW: 0.60

CPT Descriptor:

Immunoelectrophoresis; crossed (2-dimensional assay)--interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.18 on the basis that interpretation of crossed (2-dimensional) immunoelectrophoresis requires less time and expertise than interpretation of a PA and lateral chest x-ray. CMDs said it does require more expertise than interpretation of serum electrophoresis or immunoelectrophoresis services and cited 84165 (protein electrophoresis), 86320 (serum immunoelectrophoresis) and 86325 (immunoelectrophoresis of other fluids) as reference services. CMDs asked that these reference services be reduced in value to 0.16, 0.17 and 0.17, respectively. The current relative value of the 71020 PA and lateral x-ray is 0.22 with a Harvard mean total time of 5 minutes. A serum immunoelectrophoresis vignette was studied by Harvard, had a mean total time of 11 minutes, has a current value of 0.37, based on the Harvard data, and has been surveyed in the five-year refinement (see below). The 84165 and 86325 have also been surveyed in the five-year refinement process (see below) but were not previously studied.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Crossed immunoelectrophoresis for evaluation of multimeric composition of von Willebrand's factor to define whether it is a Type I or Type II deficiency, interpretation and report.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 11/11 Response Rate (%): 100% Median RVW: 0.60

25th Percentile RVW: 0.37 75th Percentile RVW: 0.75 Low: 0.30 High: 1.70

Median Pre-Service Time: 5 min. Median Intra-Service Time: 13.5 min.

25th Percentile Intra-Svc Time: 5 min. 75th Percentile Intra-Svc Time: 23 min. Low: 1 High: 25 min.

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 8 min.

ICU: N/A

Other Hospital: N/A

Office: N/A

CPT Code: 86327

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
2)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
86327	5	13.5	5	4	3.5	3
85060	5	15	5	3	3.5	3.5
84165*	3	5	5	3	3	3
86320*	4.5	9	3	3	3	3
86325*	3	8	3	3	3	2

*Selected by CMDs not survey respondents; data are from the separate survey of each of these services

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Crossed (2-dimensional) immunoelectrophoresis is used to characterize complex mixtures of antigens or antibodies. It is invaluable for the separation and investigation of each monoclonal protein (as indicated in the vignette) to identify the type of von Willebrand's factor that is deficient. In the test, the patient serum specimen is electrophoresed along one edge of a rectangular agarose gel. Once appropriate separation has been accomplished the strip is electrophoresed at right angles into gel containing a mixture of dilute, specific antibodies. Specific peaks of precipitate are formed for each individual protein within the original patient specimen for which an antibody was also present on the second electrophoresis.

The physician's interpretation requires knowledge of the patient's clinical history and the procedure process and its limitations. The interpreting physician must review a pattern composed of a series of intersecting "curves" each having the appearance of a bell-shaped curve. Understanding of the molecular structure of the protein under investigation is required so that the appropriate curve can be discerned and an accurate interpretation rendered. Interpretation of crossed immunoelectrophoresis is much more difficult than other immunoelectrophoreses because all of the antisera are mixed and the plate must be carefully examined and compared with the control to properly identify the absence of an expected protein or the presence of an unexpected protein. In other immunoelectrophoreses the physician examines a series of separate electrophoresis strips each with a single defined antibody so that when a reaction is detected the antigen-antibody is known.

The reference services chosen by the CMDs are inappropriate to the 86327 crossed immunoelectrophoresis because of the differences in time and complexity. CAP respondents in the 86327 survey did not chose these services as reference services but separate survey of the CMD-chosen references (because they are targeted for possible reduction) indicates that the 86327 requires significantly more time and difficulty (see data above). The median total survey time for the 86327 is 23.5 minutes, and the 86327 is rated higher in complexity than the other services. The crossed immunoelectrophoresis is a very low volume service with only a relatively small number of physicians providing these interpretations.

Survey respondents were split on whether the work in performing the service has changed in the last five years, with those saying yes indicating that patients requiring the service are now more complex. Two of the 11 respondents indicated that the survey vignette did not describe their typical patient.

The College of American Pathologists recommends a physician work relative value of 0.60 for the 86327 crossed (2-dimensional) electrophoresis based on the survey median and comparison to identified reference services.

CMD Comments

06-Jul-95

Code: 86327

1995 RVUs: 0.37

Recommended RVUs: 0.18

Ratio: -0.51

Long Descriptor: Immuno-electrophoresis; crossed (2-dimensional assay)

Reference Set (y/n): N Global Period: XXX Frequency: 540 Impact: -102.6

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
86327			
71020	CHEST X-RAY	0.22	XXX
84165	ASSAY SERUM PROTEINS	0.00	XXX
86320	SERUM IMMUNOELECTROPHORESIS	0.00	XXX
86325	OTHER IMMUNOELECTROPHORESIS	0.00	XXX

CMD Comment:

The interpretation of a crossed immuno-electrophoresis requires less time and expertise than the interpretation of a PA and lateral chest X-ray. It does require more expertise than the interpretation of a serum electrophoresis or immuno-electrophoresis.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
86327	30	0	25	80	20	0	0	5

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
86327	301	574	38.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
86327	13.3	6.3	-3.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
86327		
	obstetrics/gynecology	16.7
	other nonphysician prov	73.5
	pathology	9.1

Claims-Level Diagnosis Information:

CMD Comments

ICD9	Pct of Time Used	ICD9 Descriptor
86327		
070	1.3	VIRAL HEPATITIS
112	1.3	CANDIDIASIS
203	1.3	MULTIPLE MYELOMA AND IMMUNOPROLIFERATIVE NEOPLASMS
272	5	DISORDERS OF LIPOID METABOLISM
273	2.5	DISORDERS OF PLASMA PROTEIN METABOLISM
276	2.5	DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE
401	2.5	ESSENTIAL HYPERTENSION
799	2.5	OTHER ILL-DEFINED AND UNKNOWN CAUSES OF MORBIDITY AND MORTALITY

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
86327							
CMD	26		XXX		0.37		0.37

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
86327								
CMD	0.37	0.37		1.00	1.00	1.00	0.18	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
86327								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
86327									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
86327									
CMD				0.18	0.37				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 86334 Global Period: NA Current RVW: 0.37 Recommended RVW: 0.45

CPT Descriptor:

Immunofixation electrophoresis—interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.18 on the basis that interpretation of an immunoelectrophoresis requires less time and expertise than interpretation of a PA and lateral chest x-ray. CMDS said that it does require more expertise than interpretation of a serum electrophoresis or immunoelectrophoresis and cited 86325 and 86327 as additional reference services. The 71020 PA and lateral chest x-ray has a relative value of 0.22 and a Harvard total time of 5 minutes. A serum immunoelectrophoresis vignette was studied by Harvard, had a mean total time of 11 minutes, has a current value of 0.37 based on the Harvard data, and has been surveyed in the five-year refinement (see below). The 86325 has also been surveyed in the five-year refinement process (see below) but was not previously studied.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Evaluation and report of the immunofixation electrophoresis study in an 84 year old man with abnormal electrophoretic peak and equivocal immunoelectrophoretic study of serum protein.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 38/40 Response Rate (%): 95% Median RVW: 0.45

25th Percentile RVW: 0.37 75th Percentile RVW: 0.60 Low: 0.20 High: 2.22

Median Pre-Service Time: 3.5 min. Median Intra-Service Time: 6 min.

25th Percentile Intra-Svc Time: 4 min. 75th Percentile Intra-Svc Time: 10 min. Low: 0.65 High: 25 min.

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	

CPT Code: 86334

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
2)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
3)	NA		
4)	NA		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
86334	3.5	6	5	3	3	2
80500	5	6.5	0	3	3	3
85060	3.5	10	3	3	3	3
86325*	3	8	3	3	3	2
86327*	5	13.5	5	4	3.5	3

*Chosen by CMDs not survey respondents; data are from the separate surveys of these services.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Immunofixation electrophoresis is used to detect monoclonal processes in patient specimens. The patient specimen is electrophoresed along multiple strips of agarose gel and then each strip is treated with a dilute, specific anti-human serum protein (eg., rabbit anti-gamma). After washing away non-precipitated proteins, the presence of patient monoclonal protein is detected by staining the precipitated protein-antibody complexes. This allows determination of the presence of monoclonal protein and its characterization (eg, gamma-kappa).

The interpreting physician must have a knowledge of the patient's clinical history and of the procedure and its limitations. Review of the patient's clinical chemistry study results, especially the serum protein electrophoresis results, is part of the interpretation process. Identification of additional studies that are required to establish the correct nature of the monoclonal protein is part of the interpretation and report.

With the increase in sensitivity of the detection of monoclonal proteins by the use of newer serum protein electrophoretic procedures, the number and complexity of these patterns has increased. We are seeing increased numbers of patients with small amounts of monoclonal proteins and frequently biclonal processes. With the advent of better medical care leading to increased longevity of chronically ill patients, coupled with increased sensitivity of the techniques used to study patients, apparent artifacts are coming to the surface that need to be separated from true indicators of disease, eg., the ladder effect in the kappa chain studies of urine.

As the BMAD data indicate, this service is replacing immunoelectrophoresis as this technique is more definitive with less chance of a false negative result.

The survey median total time for the 86334 is 14.5 minutes, compared to 5 minutes for the radiology reference service chosen by the CMDs. Survey respondents chose the 85060 peripheral blood smear interpretation as a reference service for immunofixation electrophoresis, and the general clinical pathology consultation code 80500, not the pathology services chosen by the CMDs. The survey data for the 86334 and 85060 are similar and the 85060 has a current value of 0.45.

Most survey respondents agreed that the work of performing this service has not changed in the past five years and that the survey vignette describes their typical patient.

The College of American Pathologists recommends a physician work value of 0.45 for the immunofixation electrophoresis interpretation based on median survey data and comparison to reference services.

CMD Comments

06-Jul-95

Code: 86334

1995 RVUs: 0.37

Recommended RVUs: 0.18

Ratio: -0.51

Long Descriptor: Immunofixation electrophoresis

Reference Set (y/n): N Global Period: XXX Frequency: 63,759 Impact: -12114.21

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
86334			
	71020 CHEST X-RAY	0.22	XXX
	86325 OTHER IMMUNOELECTROPHORESIS	0.00	XXX
	86327 IMMUNOELECTROPHORESIS ASSAY	0.00	XXX

CMD Comment:

The interpretation of an immunoelectrophoresis requires less time and expertise than the interpretation of a PA and lateral chest X-ray. It does require more expertise than the interpretation of a serum electrophoresis or immunoelectrophoresis.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
86334	52.3	11.7	13.9	58.9	4.8	0.1	1.5	5.3

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
86334	30627	67308	48.2

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
86334	17.5	14.6	-1.5

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
86334		
	other nonphysician prov	73.9
	pathology	23.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
86334			

CMD Comments

06-Jul-95

203	1.3	MULTIPLE MYELOMA AND IMMUNOPROLIFERATIVE NEOPLASMS
273	2.1	DISORDERS OF PLASMA PROTEIN METABOLISM
285	1.1	OTHER AND UNSPECIFIED ANEMIAS
V72	9.4	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
86334							
CMD	26		XXX		0.37		0.37

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
86334								
CMD	0.37	0.37		1.00	1.00	1.00	0.18	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
86334								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
86334									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
86334									
CMD				0.18	0.37				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 88170 Global Period: XXX Current RVW: .50 Recommended RVW: 1.27

CPT Descriptor: Fine needle aspiration with or without preparation of smears; superficial tissue
(eg, thyroid, breast, prostate)

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

- Vignettes Used in Survey: (1) A 55 year old female presents with a palpable breast mass. Attempted aspiration reveals that it is not cystic. Fine needle aspiration biopsy is performed.
- (2) patient presents with a thyroid nodule discovered during a routine physical examination. A TSH was performed and showed normal thyroid function. A fine needle aspiration biopsy of the thyroid nodule was performed.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 511 Response Rate (%): N = 170 (33.3%) Median RVW: 1.3

25th Percentile RVW: 1.1 75th Percentile RVW: 1.7 Lowest RVW: 0.5 Highest RVW: 2.2

Median Pre-Service Time: 10 minutes Median Intra-Service Time: 15 minutes

25th Percentile Intra-Service Time: 10 minutes 75th Percentile Intra-Service Time: 20 minutes

Lowest Intra-Service Time: 3 minutes Highest Intra-Service Time: 60 minutes

Median Post-Service Time: 10 minutes

Median Complexity Source (1 = least complex, 5 = most complex):

Factor	88170	20206	32405	47000	49180	Average of all References
Mental Effort and Judgement	3.0	3.0	4.0	4.0	3.5	3.62
Technical Skill and Physical Effort	4.0	3.0	4.0	4.0	4.0	3.75
Psychological Stress	3.0	3.0	4.0	4.0	3.0	3.5

Median Time (Minutes):

Factor	88170	20206	32405	47000	49180	Average of all References
Pre-Time (median)	10	10	15	10	10	11.25
Intra-Time (median)	15	12	30	20	20	20.5
Post-Time (median)	10	10	15	10	10	11.25

Specialty: The Endocrine Society

Sample Size: 60 Response Rate (%): (36.67%) Median RVW: 1.26
 25th Percentile RVW: 1.18 75th Percentile RVW: 1.36 Lowest RVW: 0.80 Highest RVW: 2.00
 Median Pre-Service Time: 30 minutes Median Intra-Service Time: 18 minutes
 25th Percentile Intra-Service Time: 15 minutes 75th Percentile Intra-Service Time: 21.25 minutes
 Lowest Intra-Service Time: 5 minutes Highest Intra-Service Time: 30 minutes
 Median Post-Service Time: 20 minutes

KEY REFERENCE SERVICE(S):

American College of Radiology:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 20206	Biopsy, muscle, percutaneous needle	0.99
2) 32405	Biopsy, lung or mediastinum, percutaneous needle	1.93
3) 47000	Biopsy of liver, needle; percutaneous	1.90
4) 49180	Biopsy, abdominal or retroperitoneal mass, percutaneous needle	1.49

The Endocrine Society:

1) 19100	Biopsy of breast; needle core	1.27
2) 55700	Biopsy, prostate; needle or punch, single or multiple, any approach	1.57

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The work involved in code 88170 is very similar to the work required for code 19100. (As a result, code 88170 was assigned the same RVW as that for code 19100.) Moreover, the risk of complication is greater with code 88170 than for code 19100. HCFA recognized reference service code 19100 was undervalued from the Hsiao study and increased its value, but never appropriately increased the value of code 88170.

Furthermore, code 88170 compares extremely well to its key reference services from the ACR's survey (20206, 32405, 47000, and 49180) with respect to intensity and time. It was judged to be less intensive and time consuming as codes 32405, 47000, and 49180, but more than code 20206.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The majority of the respondents (ACR, 63.5 percent; ES, 63.2 percent) felt that the work involved in the procedure has not changed over the last five years. In addition, the vast majority of the respondents (ACR, 83.1 percent; ES, 85.7 percent) disagreed that technology lessened the amount of work involved in the procedure. The patients undergoing this procedure have not changed, according to half of the ACR's respondents. However, a nearly equal number (46.4 percent) thought that patients were more complex. The majority of the respondents (71.4 percent) to the Endocrine Society's survey thought that the patients were more complex. The majority of the respondents (ACR, 62.7 percent; ES, 73 percent) indicated that the site of service had not changed, but 36.1 percent of the ACR's respondents and 15.8 percent of the Society's respondents indicated a shift to outpatient settings. Lastly, the vast majority of the respondents (ACR, 88.6 percent; ES, 90.1 percent) agreed with the vignette.

ATTACHMENT
SERVICE DESCRIPTION

Code Being Rated: 88170

Fine needle aspiration with or without preparation of smears; superficial tissue (eg, thyroid, breast, prostate)

Pre-Service:

1. Obtain a clinical history.
2. Perform a physical examination of both breasts.
3. Review any available mammograms - current and previous exams.
4. Explain procedure and its purpose to the patient, including potential complications.
5. Obtain informed consent.

Intra-Service:

1. Clean biopsy site with disinfectant.
2. Inject local anesthesia (optional).
3. 21-23 gauge needle with attached syringe inserted into mass. Numerous short up and down excursions are performed with negative pressure applied to the syringe.
4. Needle withdrawn and material expressed onto slides or into a fixative.
5. Above process repeated usually once.
6. Apply compression.

Post-Service:

1. Dictate report of procedure to referring physician.
2. When results received dictate addendum to report.
3. If positive, call report to referring physician.

Public Comments

06-Jul-95

Code: 88170

1995 RVUs: 0.5

Recommended RVUs: 1.35

Ratio:

Long Descriptor: Fine needle aspiration with or without preparation of smears; superficial tissue (eg, thyroid, breast, prostate)

Reference Set (y/n): N Global Period: XXX Frequency: 39,118 Impact: 33250

Source: 4 Year: 93 Public Comment Letter: 252

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACR

Societies Wishing to Comment: ASC, ASCP, ASIM, CAP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
88170	37.8	6.1	11.1	67.4	6.8	0.1	0.9	9.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
88170	39918	42806	3.6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
88170	12.6	10.4	-1.1

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
88170	endocrinology	4.1
	general surgery	19.5
	internal medicine	2.5
	other nonphysician prov	9.8
	otolaryngology	12.1
	pathology	41.5

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
88170			

Public Comments

06-Jul-95

174	1.3	MALIGNANT NEOPLASM OF FEMALE BREAST
241	2.1	NONTOXIC NODULAR GOITER
611	4.1	OTHER DISORDERS OF BREAST
784	2.1	SYMPTOMS INVOLVING HEAD AND NECK
V72	6	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
88170							
TES	26		XXX		0.50		0.50

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
88170								
TES	0.50	0.50		1.00	1.00	1.00	1.35	252

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
88170								
TES	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	lcuvis	Offvis
88170									
TES									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
88170									
TES				1.35	0.50				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 88171 Global Period: XXX Current RVW: 1.05 Recommended RVW: 1.27

CPT Descriptor: Fine needle aspiration with or without preparation of smears; deep tissue under radiologic guidance

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

- Vignettes Used in Survey: (1) A forty-nine year old female has a non-palpable mass identified on a screening mammogram. An ultrasound exam reveals that the mass is not a simple cyst. Fine needle aspiration biopsy of the mass is performed under ultrasonic guidance. (Radiologic guidance is separately reportable.)
- (2) A patient is referred for a thyroid scan because of diffuse thyroid enlargement. A "cold" nodule is identified on the scan. The nodule is not palpable. The patient is referred for a thyroid ultrasound exam and the nodule is shown to be non-cystic. Fine needle aspiration biopsy is performed under ultrasound guidance. (Radiologic guidance is separately reportable.)

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 511 Response Rate (%): N = 172 (33.7%) Median RVW: 1.6

25th Percentile RVW: 1.4 75th Percentile RVW: 1.9 Lowest RVW: 0.6 Highest RVW: 2.7

Median Pre-Service Time: 11 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Service Time: 15 minutes 75th Percentile Intra-Service Time: 30 minutes

Lowest Intra-Service Time Estimate: 3 minutes Highest Intra-Service Time Estimate: 83 minutes

Median Post-Service Time: 10 minutes

Median Complexity Source (1 = least complex, 5 = most complex):

Factor	88171	20206	32405	47000	49180	Average of all References
Mental Effort and Judgement	4.0	3.0	4.0	4.0	4.0	3.75
Technical Skill and Physical Effort	4.0	3.0	4.0	4.0	4.0	3.75
Psychological Stress	4.0	3.0	4.0	4.0	3.0	3.5

Median Time (Minutes):

Factor	88171	20206	32405	47000	49180	Average of all References
Pre-Time (median)	11	10	15	10	15	12.5
Intra-Time (median)	20	10	30	25	20	21.25
Post-Time (median)	15	6	15	10	10	10.25

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 20206	Biopsy, muscle, percutaneous needle	0.99
2) 32405	Biopsy, lung or mediastinum, percutaneous needle	1.93
3) 47000	Biopsy of liver, needle; percutaneous	1.90
4) 49180	Biopsy, abdominal or retroperitoneal mass, percutaneous needle	1.49

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 88171 is no different from codes 88170 and 19100 with respect to physician work. It therefore should have the same RVW.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill and physical effort; mental effort and judgment; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The majority of the respondents (56.6 percent) felt that the work involved in the procedure has not changed over the last five years (43.4 percent did). In addition, the vast majority of the respondents (76.9 percent) disagreed that technology lessened the amount of work involved in the procedure (23.1 percent agreed). The patients undergoing this procedure are now more complex, according to 58.1 percent of the respondents. (Nearly 41 percent of the respondents believed that the patient has not changed.) Slightly over two-thirds (68.5 percent) the respondents indicated that the site of service had not changed, but 31.5 percent believed that it shifted to outpatient settings. Lastly, the vast majority of the respondents (92.3 percent) agreed with the vignette.

ATTACHMENT
SERVICE DESCRIPTION

Code Being Rated: 88171

Fine needle aspiration with or without preparation of smears; deep tissue under radiologic guidance. (The radiologic guidance is separately reportable.)

Pre-Service:

1. Obtain a clinical history.
2. Perform a physical examination of both breasts.
3. Review any available mammograms - current and previous exams.
4. Explain procedure and its purpose to the patient, including potential complications.
5. Obtain informed consent.

Intra-Service:

1. Clean breast with disinfectant.
2. Clean ultrasound transducer with disinfectant.
3. Inject local anesthesia (optional).
4. Localize mass under ultrasound.
5. Under ultrasound guidance, a 21-23 gauge needle with attached syringe inserted into mass. Numerous short up and down excursions are performed with negative pressure applied to the syringe.
6. Needle withdrawn and material expressed onto slides or into a fixative.
7. Repeat the above process.
8. Apply compression.

Post-Service:

1. Dictate report of procedure to referring physician.
2. When results received dictate addendum to report.
3. If positive, call report to referring physician.

Public Comments

06-Jul-95

Code: 88171

1995 RVUs: 1.05

Recommended RVUs: 1.54

Ratio:

Long Descriptor: Fine needle aspiration with or without preparation of smears; deep tissue under radiologic guidance

Reference Set (y/n): N Global Period: XXX Frequency: 5,371 Impact: 2632

Source: 2 Year: 92 Public Comment Letter: 252

Reference Services:

CMD Comment:

Societies Wishing to Survey: ACR

Societies Wishing to Comment: ASC, ASCP, ASIM, CAP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
88171	48.2	9.5	6	59.1	5.8	1.5	0.7	15.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
88171	5339	5746	3.7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
88171	40.2	33.1	-3.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
88171	other nonphysician prov	9.4
	pathology	68.9
	radiology	15.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
88171	162	2.6	MALIGNANT NEOPLASM OF TRACHEA, BRONCHUS, AND LUNG
	197	1.5	SECONDARY MALIGNANT NEOPLASM OF RESPIRATORY AND DIGESTIVE SYSTEMS

Public Comments

06-Jul-95

239	1.3	NEOPLASMS OF UNSPECIFIED NATURE
518	1.3	OTHER DISEASES OF LUNG
786	2.4	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS
789	1.5	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
V10	1.3	PERSONAL HISTORY OF MALIGNANT NEOPLASM
V72	8.8	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
88171							
TES	26		XXX	.	1.05	.	1.05

Harvard Data:

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
88171								
TES	1.05	1.05	.	1.00	1.00	1.00	1.54	252

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
88171								
TES	XXX	.	.	.	.	.	.	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdedvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
88171									
TES

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
88171									
TES	.	.	.	1.54	1.05	.	.	.	.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 88172 Global Period: N/A Current RVW: 0.60 Recommended RVW: 1.10

CPT Descriptor:

Evaluation of fine needle aspirate with or without preparation of smears; immediate cytohistologic study to determine adequacy of specimen(s).

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.56 on the basis that immediate evaluation of a fine needle aspirate to determine the adequacy of a specimen for cytohistologic study requires no more time or expertise than interpretation of cytopathological fluids, washings, brushings or smears (88104); it is the same type of examination, they said. CMDs also commented that in actuality it requires only a notification that the material is "adequate" for study, does not require a definite tissue interpretation, and the pathologist is required to render this judgement in an unscheduled setting. The CMDs choose 88104, Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation as their Reference Service. The 88104 has a current relative value of 0.56 and the Harvard mean total time is 17 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A fine needle aspiration is being performed for evaluation of a 1.0 cm lung nodule in a 56 year old male with Chronic Obstructive Pulmonary Disease (COPD). You are asked to immediately evaluate the smears to determine if the specimen is adequate to make a definitive diagnosis.

Description of Pre-Service Work:

Preparing to examine the specimen; obtaining and reviewing the history and diagnostic studies, including examination of previous slides or reports; review of literature or research and communicating with other professionals prior to examination of the specimen.

Description of Intra-Service Work:

Performing the gross examination, handling and processing; microscopic examination; any required photography or research as necessary to make a final diagnosis; any dictation or report preparation performed during the specimen examination; communicating with other professionals during the examination.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 36/58 Response Rate (%): 62% Median RVW: 1.10

25th Percentile RVW: 0.73 75th Percentile RVW: 1.27 Low: 0.20 High: 3.00

Median Pre-Service Time: 10 min. Median Intra-Service Time: 19 min.

25th Percentile Intra-Svc Time: 12 min. 75th Percentile Intra-Svc Time: 30 min. Low: 1 min. High: 55 min.

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 10 min.

ICU: N/A

Other Hospital: N/A

Office: N/A

CPT Code: 88172

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	88331	Pathology consultation during surgery; with frozen section(s), single specimen	1.19
2)	N/A		
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
88172	10	19	10	4	3	4
88331	5	16	7.5	5	4	5

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

When a fine needle aspiration (FNA) procedure is performed, it is impossible to know if the lesion has been sampled adequately unless a slide is immediately examined microscopically. This is important because if the sample appears inadequate for diagnosis, the FNA can be repeated while the patient is still present - obviating the need to repeat the FNA at a later date, thus sparing the patient needless anxiety, inconvenience, and expense.

This immediate cytohistologic evaluation to determine FNA specimen adequacy generally requires the presence of the pathologist in the CAT scan facility or at the patient's bedside. Typically, the patient's history is reviewed with the attending physician before the procedure, and the CAT scan or ultrasound image is reviewed with the radiologist prior to collecting the sample. When the sample is received, smears are prepared and the pathologist selects a slide to stain and examine immediately under the microscope. In order to determine that the specimen is adequate, diagnostic cells (usually malignant) must be identified - often resulting in a provisional diagnosis as well. The definitive diagnosis is deferred until all the slides can be stained and examined. If the specimen is judged to be inadequate for diagnosis, the FNA is repeated. This immediate cytohistologic evaluation requires considerable expertise. It is done under great pressure, since the decision to repeat or terminate the FNA procedure is contingent upon the result, which both the operating physician and patient are awaiting.

In comments made to the HCFA in 1992 concerning the initial Medicare RV's, the CAP requested that the RV for 88172 be increased from 0.64 to 1.13. This was denied. This request was again made in 1993 - and again denied. Although we continued to feel that the 88172 was undervalued, we did not request an increase in value as part of the five-year refinement process because we thought that physician work for this service had not changed. Subsequently, the CMD's stated that they felt the time and expertise for 88172 was comparable to that of the cytologic evaluation of Body Fluids, Washings, and Brushings (88104) - and recommended that the RV be reduced from 0.60 to 0.56. We felt that the 88104 was an inappropriate Reference Service, since diseases evaluated by cytologic evaluation of fluids, washings, and brushings are usually in a more advanced Stage productive of many more diagnostic cells than the earlier Stage lesions typically evaluated by FNA - thereby requiring less mental effort and judgement. In addition, while an equivocal cytology diagnosis on fluids, washings, and brushings necessitates at most a non-invasive biopsy, an equivocal FNA diagnosis usually will be followed by an invasive surgical procedure - thus increasing the pressure/stress to make a definitive diagnosis without asking for additional material. In fact, the 88172 is similar to the 88131, frozen section during surgery, since both involve an immediate diagnosis, made under pressure, with significant implications for patient management.

As a result of the CMD's recommendation, the CAP conducted a Survey of 88172 for physician work. The results indicate a median RVW of 1.10, which is twice the RVW of the 88104 and somewhat less than the RVW (1.19) for the frozen section (88131) - clearly indicating that the physician work of 88172 is not comparable to the 88104. In addition, 73% of respondents felt this service has become more complex over the past 5 years - apparently because the immediate evaluation of FNA specimens is no longer restricted to a determination of specimen adequacy, but expanded to the rendering of a provisional diagnosis as well. Had the CAP fully appreciated this change in the physician work for 88172, we would have requested an increase in the RVW as part of the five-year refinement process. We are now requesting that the RVW for 88172 be increased to the Survey median of 1.10.

CMD Comments

06-Jul-95

Code: 88172

1995 RVUs: 0.6

Recommended RVUs: 0.56

Ratio: -0.07

Long Descriptor: Evaluation of fine needle aspirate with or without preparation of smears; immediate cytohistologic study to determine adequacy of specimen(s)

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 59,659 **Impact:** -2386.36

Source: 4 **Year:** 93 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
88172			
	88104 MICROSCOPIC EXAM OF CELLS	0.56	XXX

CMD Comment:

The evaluation of fine needle aspirate for immediate cytohistologic study to determine adequacy of specimen is certainly requires no more time or expertise than the interpretation of cytopathological fluids (washings, brushings, or smears). It is the same type of examination. In actuality it requires only a notification that the material is "adequate" for study. It does not require a definite tissue interpretation. The pathologist is required to render this judgement in an unscheduled setting.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASC, ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
88172	42	7.4	10.2	51.6	5	0.4	0.5	7.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
88172	58984	66222	6

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
88172	38.5	35.3	-1.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
88172		
	other nonphysician prov	8.1
	pathology	88.6

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
88172			

CMD Comments

06-Jul-95

162	4	MALIGNANT NEOPLASM OF TRACHEA, BRONCHUS, AND LUNG
197	1.1	SECONDARY MALIGNANT NEOPLASM OF RESPIRATORY AND DIGESTIVE SYSTEMS
239	1.4	NEOPLASMS OF UNSPECIFIED NATURE
786	1.6	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS
799	1.4	OTHER ILL-DEFINED AND UNKNOWN CAUSES OF MORBIDITY AND MORTALITY
V72	9.8	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
88172							
CMD	26		XXX		0.60		0.60

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
88172								
CMD	0.60	0.60		1.00	1.00	1.00	0.56	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
88172								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
88172									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
88172									
CMD				0.56	0.60				

CPT Code: 88173 Global Period: N/A Current RVW: 1.08 Recommended RVW: 1.59

CPT Descriptor:

Evaluation of fine needle aspirate with or without preparation of smears; interpretation and report.

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.56 on the basis that the interpretation of a FNA of the breast required no more time or expertise than interpretation of cytopathological washings from a transbronchial brushing or washing (88104). The current relative value of the 88104, Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation, is 0.56 and the Harvard mean total time is 17 minutes.

The College of American Pathologists asked that the relative value be increased to 1.60 on the basis of a change in the physician work since Harvard studied the service. In brief, the types of specimens composing FNA specimens are much more difficult to definitively diagnose than in 1990 when Harvard surveyed and the expectation that a definitive diagnosis will be rendered without additional invasive procedure(s) has increased, thus increasing the work of the physician. The CAP also chose the 88104 as the Reference Service but commented that the work involved in the 88104 is less demanding than in 88173 services provided today.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Definitive diagnosis of a 1.0 cm lung nodule in a 56 year old male with Chronic Obstructive Pulmonary Disease (COPD), interpretation and written report.

Description of Pre-Service Work:

Preparing to examine the specimen; obtaining and reviewing the history and diagnostic studies, including examination of previous slides or reports; review of literature or research and communicating with other professionals prior to examination of the specimen.

Description of Intra-Service Work:

Performing the gross examination, handling and processing; microscopic examination; any required photography or research as necessary to make a final diagnosis; any dictation or report preparation performed during the specimen examination; communicating with other professionals during the examination.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

Specialty: Pathology—College of American Pathologists

Sample Size: 35/58 Response Rate (%): 60 Median RVW: 1.59

25th Percentile RVW: 1.20 75th Percentile RVW: 1.70 Low: 0.56 High: 3.50

Median Pre-Service Time: 15 min. Median Intra-Service Time: 25 min.

25th Percentile Intra-Svc Time: 15 min. 75th Percentile Intra-Svc Time: 30 min. Low: 1 min. High: 40 min.

Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	<u>10 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	

CPT Code: 88173

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	RVW
1)	88307	Level V Surgical pathology, gross and microscopic examination	1.59
2)	88104	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation	.56

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
88173	15	25	10	5	3	4
88307	10	21	10	4	4	4
88104	5	15	0	3	3	3

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

A Fine Needle Aspiration (FNA) is usually performed to establish a diagnosis on a tumor. The evaluation and definitive diagnosis of an FNA specimen involves examining a minimum of 8-10 slides, each of which must be examined very thoroughly so that the small number of diagnostic cells typically present (often malignant) are not overlooked. This service was studied by Harvard in 1990 and assigned a RWV of 1.18. This RWV was reduced to 1.06 when the final RVS was implemented in 1991, which was approximately twice the value of interpreting a peripheral blood smear (PBS). Yet, the interpretation of a PBS involves looking at only a single slide, usually does not involve a diagnosis of malignancy, and requires considerably less skill and effort. Therefore, in 1992 when the CAP submitted written comments to the HCFA regarding the initial Medicare RV's, we requested that the 88173 RWV be restored to its original RWV of 1.18. This request was denied. This request was again made in 1993 - and again denied.

In comments made to the HCFA this year concerning the five-year refinement process, the only service which we identified as being undervalued was the 88173, FNA interpretation. Specifically, we requested that the RWV for 88173 be increased from its current value of 1.08 to 1.60, because there has been a change in physician work since this service was studied by Harvard in 1990. At the time of the Harvard study, FNA was a relatively new procedure performed primarily on advanced lung, thyroid, and breast tumors (96,954 frequency in 1991). Since then additional organs such as liver, kidney, adrenal, pancreas, lymph nodes, and salivary gland have become common sites for FNA diagnosis (157,890 frequency in 1994). Even more importantly, improvements in CAT scan and diagnostic ultrasound technology have made it possible to identify and sample much smaller lesions at an earlier Stage of the disease process. This means we are now seeing specimens from borderline and/or early lesions, which contain fewer diagnostic cells - resulting in more effort to arrive at a diagnosis. Cytologic changes are often more subtle than they are in more advanced Stage lesions, thus requiring more mental effort and judgement. In addition, at the time of the Harvard study, the FNA was thought of as a screening procedure to identify lesions which should receive confirmatory biopsy. Today the FNA is regarded as a definitive diagnostic procedure, which is expected to minimize the costs and risks associated with confirmatory biopsy - thereby increasing physician stress during the interpretation and increasing the subsequent liability risk resulting from misdiagnosis.

We selected the cytologic diagnosis of fluids, washings, and brushings (88104) as a Reference Service (RWV 0.56), since it too was studied by Harvard as a total work service - thereby facilitating comparison. We felt that the 88104 was a much less demanding service, because lesions evaluated from fluids, washings, and brushings are usually in a more advanced Stage productive of many more diagnostic cells than the earlier Stage lesions typically evaluated by FNA - thereby requiring less mental effort and judgement. In addition, while an equivocal cytology diagnosis on fluids, washings, and brushings necessitates at most a non-invasive biopsy, an equivocal FNA diagnosis is usually followed by an invasive surgical procedure - thus increasing the pressure/stress to make a definitive diagnosis without asking for additional material.

Subsequently, the CMD's stated that they felt the time and expertise required to interpret a breast FNA (88173) was comparable to the cytologic evaluation of transbronchial washings or brushings (88104) - and recommended that the RV be reduced from the current 1.08 to 0.56. The CAP conducted a Survey of 88173 for physician work. The results of this survey indicate a median RWV of 1.59, which is almost three times the RWV of the 88104 - clearly indicating that the physician work of 88173 is not comparable to the 88104. In addition, 100% of respondents answering Step 4b felt this service has become more complex over the past 5 years - confirming that there has been an increase in physician work since the Harvard study. This Survey also validates our initial request for an increase in the RVW to 1.60, and we are now requesting that the RVW for 88173 be increased to the Survey median of 1.59.

CMD Comments

06-Jul-95

Code: 88173

1995 RVUs: 1.08

Recommended RVUs: 0.56

Ratio: -0.48

Long Descriptor: Evaluation of fine needle aspirate with or without preparation of smears; interpretation and report

Reference Set (y/n): N Global Period: XXX Frequency: 141,713 Impact: -73690.76

Source: 5 Year: 93 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
88173			
	88104 MICROSCOPIC EXAM OF CELLS	0.56	XXX

CMD Comment:

The interpretation of a fine needle aspirate of the breast requires no more time or expertise than the interpretation of cytopathological washings from a transbronchial brushing or washing.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASC, ASCP, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
88173	43	8	10	58.8	7	0.2	0.6	7.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
88173	137807	157890	7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
88173	30.1	27.5	-1.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
88173		
	group practices	3.3
	other nonphysician prov	12.2
	pathology	82.7

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
88173			
	162	2.3	MALIGNANT NEOPLASM OF TRACHEA, BRONCHUS, AND LUNG

CMD Comments

06-Jul-95

239	1.2	NEOPLASMS OF UNSPECIFIED NATURE
611	1.8	OTHER DISORDERS OF BREAST
786	1.1	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS
V72	8.9	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
88173							
CAP	26	XXX	XXX	1.13	1.08	0.96	1.01
CMD	26	XXX	XXX	1.13	1.08	0.96	1.01

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
88173								
CAP	1.08	1.08	0.89	1.07	1.00	1.00	1.60	315
CMD	1.08	1.08	0.89	1.07	1.00	1.00	0.56	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
88173								
CAP	XXX	1.13	t	.		36	t	.
CMD	XXX	1.13	t	.		36	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
88173									
CAP
CMD

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
88173									
CAP	.	.		1.60	1.08	pa	n	0.031	
CMD	.	.		0.56	1.08	pa	n	0.031	

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 88180 Global Period: N/A Current RVW: 0.36 Recommended RVW: 0.60

CPT Descriptor:

Flow cytometry; each cell surface marker

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced on the basis that the average number of cell surface markers billed for each submission of this code is 10, equating to a total relative value of 3.60, and that the skill and time involved at the level of 3.60 does not equal the skill and time involved with 77430 Weekly radiation therapy management; complex (RV=3.60), 31600 Tracheostomy, planned (separate procedure) (RV=3.62), or 99291 Critical Care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; first hour (RV=3.64). CMDs said that reduction of the relative value to 0.16 equals a total of 1.60 which better equates with 88325 (Pathology) Consultation, comprehensive, with review of records and specimens, with report on referred material (RV=2.22) and 88307 Level V Surgical pathology, gross microscopic examination (RV=1.59). The 31600 Tracheostomy was studied by Harvard and has a mean total time of 82 minutes. The radiology service was apparently not studied by Harvard.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Immunophenotyping of a lymph node cell suspension from a 65 year old male with lymphadenopathy, fever, and weight loss, each cell surface marker, interpretation and report.

Description of Pre-Service Work:

Preparing to examine the specimen; obtaining and reviewing the history and diagnostic studies, including examination of previous slides or reports; review of literature or research and communicating with other professionals prior to examination of the specimen.

Description of Intra-Service Work:

Performing the gross examination, handling and processing; microscopic examination; any required photography or research as necessary to make a final diagnosis; any dictation or report preparation performed during the specimen examination; communicating with other professionals during the examination.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 29/49 Response Rate (%): 59% Median RVW: 0.60

25th Percentile RVW: 0.24 75th Percentile RVW: 1.36 Low: 0.16 High: 2.26

Median Pre-Service Time: 5 min. Median Intra-Service Time: 10 min.

25th Percentile Intra-Svc Time: 3.5 min. 75th Percentile Intra-Svc Time: 30 min. Low: 2 min. High: 50 min.

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 10 min.

ICU: N/A

Other Hospital: N/A

Office: N/A

CPT Code: 88180

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
2)	88305	Level IV Surgical pathology, gross and microscopic examination	0.75

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
88180	5	10	10	4	4	4
85060	1.5	6	2	3	3	3
88305	2	22.5	4	4	4	4

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Flow Cytometry, each cell surface marker (88180) requires significant technical skill, mental effort and judgment and stress. This code generally involves the diagnosis and determination of whether or not a patient has leukemia, lymphoma, or an immunodeficiency state. The clinical implications and consequences of such serious diagnoses include chemotherapy and radiation therapy, treatments with significant morbidity and mortality. The diagnosis of immunodeficiency has significant associated psychosocial and prognostic implications (AIDS). Therefore, correct diagnosis is associated with significant mental effort, judgment and stress.

Pre-service work for 88180 often includes communication with a clinician (e.g., hematologist, oncologist, internist, or surgeon) to obtain clinical information, history and physical exam findings. The pathologist is often required to discuss with the clinician proper collection, handling and transport of specimens because cell viability is crucial for performance of these studies. The pathologist must review other clinical laboratory data, including the CBC and peripheral blood smear to determine the presence of abnormal cells.

Intra-service work includes gross examination of the specimen, and selection of a portion of the tissue for flow cytometry studies while retaining sufficient tissue for surgical pathology examination. The tissue must then be disaggregated to make a single cell suspension. If the specimen is blood or bone marrow, smears must be reviewed to determine the presence of abnormal cells and their percentage in order to make a determination of what type of preparation and staining method should be used (e.g., whole blood versus density gradient separation). Similar touch imprints, smear, or cytopsin review of lymph node cells is required. The pathologist must review the viability of the specimen. The pathologist selects the appropriate panel of antibodies depending on clinical history and morphologic impression. If the sample is limited, the pathologist must prioritize which antibodies will be used to characterize/immunophenotype the abnormal cell population.

After the technologist stains the sample and begins to run the samples on the flow cytometer, the pathologist verifies that the correct population is bit mapped (electronically selected) for analysis. After all tubes are run, the pathologist reviews the histograms in conjunction with morphologic findings (histologic sections, blood or bone marrow smears) and other lab results (e.g., cytochemical stains, TdT, cytogenetics) to determine the composite immunophenotype and final diagnosis. The pathologist dictates or writes the final report.

Post service work includes finalization of the report often requiring review of current literature. Results are usually discussed with multiple individuals (i.e., surgeon, oncologist, hematologist, radiation therapist, internist). Because of the sophisticated and specialized expertise required for interpretation of these results, the pathologist must spend considerable time and effort in helping clinicians understand the results as they relate to correct diagnosis, guiding appropriate therapy and determining prognosis. Additional studies may be recommended (eg. cytogenetics, molecular methods) if flow studies are inconclusive or other studies can contribute to treatment decisions or prognosis.

The CAP survey data show a median total time of 25 minutes per cell surface marker or a total of 250 minutes for the 10 marker average stated by the CMDs as the average case. This is significantly more time than that involved in either the 31600 tracheostomy (82 minutes) or the hour of critical care (99291). Survey respondents chose as reference services the 85060 peripheral blood smear interpretation (valued at 0.45) and the 88305 level IV surgical pathology examination (valued at 0.75) and rated the flow cytometry marker between the two in value at 0.60. This corresponds to survey responses that place the median time for the flow cytometry marker between the times for the two references (but closer to the time of the higher valued service) and place the flow cytometry complexity equal to that of the higher valued reference.

Flow cytometry is a specialized service not widely provided. Those who do provide it generally agreed that the work of performing the service has changed in the last 5 years. Approximately half of respondents felt that patients requiring the service are now more complex, but generally did not feel that the technology has become more familiar and thus less work. Survey respondents agreed that the survey vignette described their typical patient.

Flow cytometry was not studied by Harvard and the current value is based on extrapolation. During the first HCFA refinement opportunity in 1992 the CAP identified the 88180 as undervalued and asked that its value be tripled on the basis of the amount of work required in the service. The service remains undervalued as demonstrated by the current survey data.

The College of American Pathologists recommends a value of 0.60 for the 88180 flow cytometry service based on the median survey data and comparison to reference services.

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CMD Comments

06-Jul-95

Code: 88180

1995 RVUs: 0.36

Recommended RVUs: 0.16

Ratio: -0.56

Long Descriptor: Flow cytometry, each cell surface marker

Reference Set (y/n): N Global Period: XXX Frequency: 244,922 Impact: -48984.4

Source: 7 Year: 93 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
88180			
	31600 INCISION OF WINDPIPE	3.62	000
	77430 WEEKLY RADIATION THERAPY	3.60	XXX
	88307 TISSUE EXAM BY PATHOLOGIST	1.59	XXX
	88325 COMPREHENSIVE REVIEW OF DATA	2.22	XXX
	99244 OFFICE CONSULTATION	2.23	XXX

CMD Comment:

The average number of cell surface markers billed for each submission of this code is 10. This equates with the 1995 RVUs of 0.36, to a total of 3.60. The skill and time involved at level of 3.6 does not equal the skill and time involved with 77430, 31600, or 99291. Reduction of the RVUs to 0.16 equals a total RVUs of 1.60, which better equates with 88325 and 88307.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASC, ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
88180	24.7	4.5	14.5	41.2	25.8	11.6	4.8	2.3

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
88180	130505	264210	42.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
88180	26.4	20.7	-2.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
88180		
	hematology/oncology	3.6
	other nonphysician prov	42.6
	pathology	48.4

CMD Comments

06-Jul-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
88180	202	3.3	OTHER MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE
	204	1.2	LYMPHOID LEUKEMIA
	205	1.3	MYELOID LEUKEMIA
	208	1.1	LEUKEMIA OF UNSPECIFIED CELL TYPE
	996	1.6	COMPLICATIONS PECULIAR TO CERTAIN SPECIFIED PROCEDURES
	V42	1.8	ORGAN OR TISSUE REPLACED BY TRANSPLANT
	V72	8.6	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
88180	CMD	26		XXX		0.36		0.18

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
88180	CMD	0.36	0.36		2.00	1.00	1.00	0.16	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
88180	CMD	XXX							

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
88180	CMD									

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
88180	CMD				0.16	0.36				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 88182 Global Period: N/A Current RVW: 0.77 Recommended RVW: 0.75

CPT Descriptor:

Flow cytometry; cell cycle or DNA analysis

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.34 on the basis that the number of billings on each claim for this code averages 10; ten times this value is 7.60 (actually 7.70), an extreme value for this code. If the same percentage reduction is applied that was used for 88180, the value for this code would be 0.34. The CMDs chose the 88180 flow cytometry, each cell surface marker as the reference service.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

DNA cell cycle (S-phase) analysis on a 2 cm mammographically suspicious breast mass biopsy in a 63 year old female, interpretation and report.

Description of Pre-Service Work:

Preparing to examine the specimen; obtaining and reviewing the history and diagnostic studies, including examination of previous slides or reports; review of literature or research and communicating with other professionals prior to examination of the specimen.

Description of Intra-Service Work:

Performing the gross examination, handling and processing; microscopic examination; any required photography or research as necessary to make a final diagnosis; any dictation or report preparation performed during the specimen examination; communicating with other professionals during the examination.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 24/35 Response Rate (%): 69% Median RVW: 0.75

25th Percentile RVW: 0.50 75th Percentile RVW: 1.00 Low: 0.30 High: 1.67

Median Pre-Service Time: 4 min. Median Intra-Service Time: 10 min.

25th Percentile Intra-Svc Time: 8 min. 75th Percentile Intra-Svc Time: 16.5 min. Low: 4.5 min. High: 20 min.

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>6 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	
		CPT Code: <u>88182</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
2)	88305	Surgical pathology, gross and microscopic examination	0.75
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
88182	4	10	6	4	3.5	2
85060	3	7	2	3	3	3
88305	2	16	5	4	3.5	4

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Flow Cytometry (FCM), cell cycle or DNA analysis (88182), two separate tests, require significant technical skill, mental effort and stress. This code represents new technology with significant prognostic implications in many tumor cell types. This technology may also be used as an adjunct in the diagnosis of malignancy in body fluids.

Pre-service work includes communication with surgeons and clinicians on the correct methods of specimen collection and transport and patient history.

Intra service work includes examination of the specimen, selection of representative tumor while maintaining the integrity of the specimen for surgical pathology gross and microscopic examination, and selection of appropriate diploid control tissue. The pathologist or technologist will mechanically or enzymatically disaggregate cells for isolation of nuclei. The pathologist will work with the technologist to select the best nuclear preparation technique. Once the sample is stained, the pathologist will assist the flow cytometry technologist in instrument settings and selection (bitmapping) of the nuclear/cell population of interest. The pathologist examines the histograms and selects the appropriate mathematical model (software) for analysis of this non-parametric data. The pathologist determines whether 1) there is a cell population with an abnormal DNA content (aneuploid), and 2) if there is an increase in the proliferating cell population usually expressed as five phase fraction; thus code 88182 involves two units of service, each a different test. The DNA ploidy and cell cycle analysis results are reported in conjunction with review of the surgical pathology microscopic findings, tumor grade, stage, and review of a nuclear preparation to confirm that the specimen analyzed is representative of the tumor cell population. A report is prepared and issued with a narrative interpretation.

Post-service work often includes discussion of results and diagnostic and prognostic implications with clinicians, especially surgeons and oncologists. The pathologist may suggest other adjunctive, complimentary, or more specific studies such as molecular biology or cytogenetics.

The CMD's have suggested that the RVW be reduced to 0.34 on the basis that the number of units for billing on each claim for this code averages ten and ten times 0.77 is 7.70, an extreme for this code. The basis for the reduction is erroneous. The 88182 code describes two types of service, DNA cell cycle and ploidy analysis. The maximum number of units for any single patient specimen would be two; two times the current relative value for the 88182 is 1.54.

The median survey RVW for the 88182 is 0.75, affirming the current relative value. Survey respondents chose the 85060 peripheral blood smear interpretation (relative value 0.45) and the 88305 level IV surgical pathology examination (relative value 0.75) as the reference services. The survey median total time for the 88182 is 20 minutes, close to the time for the 88305 and well above the time for the 85060. Respondents rated the 88182 between the 85060 and the 88305 in complexity.

Half of the 24 survey respondents felt that the work of performing this service has changed in the past five years, probably because of the wealth of literature to review and digest and the more sophisticated software analysis and data interpretation required for these studies. There was no agreement on whether the technology is more familiar or on whether patients are more complex or have not changed (no respondent indicated that patients are less complex). Twenty of 24 respondents felt that the survey vignette described their typical patient.

The College of American Pathologists recommends a physician work relative value of 0.75 for the 88182 flow cytometry cell cycle or DNA analysis based on median survey data and comparison to reference services.

CMD Comments

06-Jul-95

Code: 88182 1995 RVUs: 0.77 Recommended RVUs: 0.34 Ratio: -0.56

Long Descriptor: Flow cytometry, cell cycle or DNA analysis

Reference Set (y/n): N Global Period: XXX Frequency: 38,131 Impact: 0

Source: 4 Year: 93 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
88182			
	88180 CELL MARKER STUDY	0.36	XXX

CMD Comment:

Again, the number of billings on each claim for this code averages 10. Ten times 0.76 equals 7.60 which are extreme RVUs for this code. If the same percentage reduction is applied that was used for 88180, the RVUs for this code would be 0.34.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASC, ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
88182	44.9	9.3	7.3	57.2	3.8	0	0.3	2.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
88182	47227	43330	-4.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
88182	22.8	23.8	0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
88182		
	other nonphysician prov	57.9
	pathology	39.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
88182			
	174	3.5	MALIGNANT NEOPLASM OF FEMALE BREAST
	185	1.1	MALIGNANT NEOPLASM OF PROSTATE

CMD Comments

188	2.2	MALIGNANT NEOPLASM OF BLADDER
233	1.7	CARCINOMA IN SITU OF BREAST AND GENITOURINARY SYSTEM
599	5.3	OTHER DISORDERS OF URETHRA AND URINARY TRACT
V72	5.2	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
88182							
CMD	26		XXX		0.77		0.77

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
88182								
CMD	0.77	0.77		1.00	1.00	1.00	0.34	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
88182								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
88182									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
88182									
CMD				0.34	0.77				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 88311 Global Period: N/A Current RVW: 0.24 Recommended RVW: 0.24

CPT Descriptor:

Decalcification procedure (List separately in addition to code for surgical pathology examination)

Source and Summary of Comment to HCFA on this service:

CMDs asked that the physician work relative value be reduced to 0.00 saying that this is a technical procedure that requires no physician work; it should be paid as a technical component only.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Decalcification of a trephine bone biopsy (not including surgical pathology examination)

Description of Pre-Service Work:

Preparing to examine the specimen; obtaining and reviewing the history and diagnostic studies, including examination of previous slides or reports; review of literature or research and communicating with other professionals prior to examination of the specimen.

Description of Intra-Service Work:

Performing the gross examination, handling and processing; microscopic examination; any required photography or research as necessary to make a final diagnosis; any dictation or report preparation performed during the specimen examination; communicating with other professionals during the examination.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 31/31 Response Rate (%): 100% Median RVW: 0.24

25th Percentile RVW: 0.20 75th Percentile RVW: 0.27 Low: 0.07 High: 0.50

Median Pre-Service Time: 0 min. Median Intra-Service Time: 5 min.

25th Percentile Intra-Svc Time: 5 min. 75th Percentile Intra-Svc Time: 8 min. Low: 1.5 min. High: 20 min.

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>2 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	

CPT Code: 88311

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	88302	Level II Surgical pathology examination	0.13
2)	88304	Level III Surgical pathology examination	0.22
3)	N/A		
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
88311	0	5	2	2	2	1.5
88302	2	5	4	2	2	2
88304	3	5.5	3	2	2	2

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Decalcification is a time critical procedure. The time is different from specimen to specimen based on variables of size and density, and must be established empirically by testing. Underdecalcification results in a specimen which is difficult to section yielding extensive histological artifact. Overdecalcification results in loss of nuclear and cellular detail and stain avidity. Both yield less than optimal, frequently unsatisfactory specimens. To achieve the appropriate level of decalcification, the physician must test the specimen periodically during the process to determine if adequate decalcification has been achieved. This is accomplished by manipulating the tissue by hand and/or with instruments such as forceps and scalpel to feel for evidence of residual calcification.

Decalcification was studied by Harvard and had a total time of 5 minutes. The same vignette that was used by Harvard was used by the CAP in its survey. The CAP survey median intra-service time for the 88311 is 5 minutes and 10 of 31 respondents indicated that there is also post-service time (median 2 minutes). There really is no pre- or post-service time included in the 88311 for the decalcification procedure. Any pre- or post-service activities that are associated with the decalcification procedure are included in the pre- and post-service time of the associated primary surgical pathology examination. We surmise that survey respondents did not understand that coding and/or payment convention.

Removing the post-service time reported by a minority of survey respondents, the median total time for the decalcification procedure (which is intra-service only) is the same as the Harvard mean total time and the same as the two reference services' intra-service time, affirming that there is physician work and that the Harvard survey time is probably accurate. In addition, survey respondents agreed that the work of performing the service has not changed in the past 5 years and that the survey vignette describes their typical patient. The survey median work value for the decalcification procedure is 0.24, the same as the current physician work relative value.

The College of American Pathologists recommends that the current physician work value for the decalcification procedure 88311 be maintained at 0.24 based on median survey data that support both the current value and the fact that there is physician work involved in the service.

E:\USER\JAC\SURVEY95\SUM88311

CMD Comments

06-Jul-95

Code: 88311

1995 RVUs: 0.24

Recommended RVUs: 0

Ratio: -1.00

Long Descriptor: Decalcification procedure (List separately in addition to code for surgical pathology examination)

Reference Set (y/n): N Global Period: XXX Frequency: 411,314 Impact: -98715.36

Source: 3 Year: 92 Public Comment Letter:

Reference Services:

CMD Comment:

This is a technical procedure that requires no physician work. It should be paid as a Technical Component only.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ASCP

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
88311	48.2	11.6	9.9	58.2	7.5	0.4	1.8	9.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
88311	400536	458284	7

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
88311	69.7	68.1	-0.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
88311	group practices	2.3
	other nonphysician prov	10.6
	pathology	85.8

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
88311	715	5	OSTEOARTHROSIS AND ALLIED DISORDERS
	820	2.1	FRACTURE OF NECK OF FEMUR
	V72	8.1	SPECIAL INVESTIGATIONS AND EXAMINATIONS

CMD Comments

06-Jul-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
88311							
CMD	26	XXX	XXX	0.07	0.24	3.43	0.24

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
88311								
CMD	0.24	0.24	3.43	1.00	1.00	1.00	0.00	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
88311								
CMD	XXX	0.07	t	.		5	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
88311									
CMD

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
88311									
CMD	.	.	.	0.00	0.24	pa	n	0.014	

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 89060 Global Period: N/A Current RVW: 0.37 Recommended RVW: 0.45

CPT Descriptor:

Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)-interpretation and report

Source and Summary of Comment to HCFA on this service:

CMDs asked that the relative value be reduced to 0.16 on the basis that the time and expertise for examining fluid for crystals is no greater than the interpretation of a PA and lateral chest x-ray. The current value for the 71020 PA and lateral x-ray is 0.22 and the Harvard time is 5 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Preparation direct and polarized light evaluation and report of fluid from the swollen knee joint of a 55 year old man.

Description of Pre-Service Work:

Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test result.

Description of Intra-Service Work:

Interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination of the test result; any dictation or report preparation performed during examination of the test result.

Description of Post-Service Work:

Report preparation and finalization; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports, after examination of the specimen; arranging for further studies or other services.

SURVEY DATA:

Specialty: Pathology--College of American Pathologists

Sample Size: 31/40 Response Rate (%): 78% Median RVW: 0.45

25th Percentile RVW: 0.40 75th Percentile RVW: 0.55 Low: 0.15 High: 1.00

Median Pre-Service Time: 2.5 min. Median Intra-Service Time: 10 min.

25th Percentile Intra-Svc Time: 6 min. 75th Percentile Intra-Svc Time: 15 min. Low: 3 min. High: 30 min.

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>3 min.</u>	
ICU:	<u>N/A</u>	
Other Hospital:	<u>N/A</u>	
Office:	<u>N/A</u>	

CPT Code: 89060

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	85060	Blood smear, peripheral, interpretation by physician with written report	0.45
2)	80500	Clinical pathology consultation; limited, without review of patient's history and medical records	0.37
3)	88104	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation	0.56
4)	N/A		

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CODE	TIME IN MINUTES			COMPLEXITY		
	PRE	INTRA	POST	MENTAL	TECHNICAL	PSYCH
89060	2.5	10	3	3	3	4
85060	2.5	8.5	3	4	3	3
80500	5	6.5	2	3	3	3
88104	4	10	5	4	3	4

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This interpretation involves the evaluation of wet preparations of body fluid, including joint and biliary drainage fluids, and is especially useful in determination of crystal material within joint fluid in conditions such as gout and pseudogout. The specimen is first evaluated by the pathologist visually and gross characteristics are noted. Technical staff will then usually centrifuge the specimen for concentration and produce two or more wet preparations for microscopic examination. This microscopic study is generally performed using a polarized light attachment. Prior to the polarization the interpreting physician will review data from the joint fluid analyses. Polarization of this specimen is then performed with evaluation of positive and negative birefringence of the crystalline material and semiquantitation of the amount of this crystalline material present. A written report of the findings and a presumptive diagnosis is rendered.

The median survey time for the crystal identification 89060 is 15.5 minutes, well above the total time for the radiology reference service chosen by the CMDs. Survey respondents chose the general clinical pathology consultation 80500, the peripheral blood smear interpretation 85060, and the nongynecological cytopathology fluids interpretation as reference services, and gave the crystal identification time and complexity estimates inside the range of estimates for those services. The physician work relative values for the reference services are 0.37, 0.45 and 0.56, and the median work value for the 898060 is 0.45.

Survey respondents agreed that the work of performing this service has not changed in the past five years and that the survey vignette describes their typical patient.

The College of American Pathologists recommends a physician work value of 0.45 for the crystal identification based on median survey data and comparison to reference services.

CMD Comments

06-Jul-95

Code: 89060

1995 RVUs: 0.37

Recommended RVUs: 0.16

Ratio: -0.57

Long Descriptor: Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)

Reference Set (y/n): N Global Period: XXX Frequency: 47,324 Impact: -9938.04

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
89060			
	71022 CHEST X-RAY	0.31	XXX

CMD Comment:

Time and expertise for examining fluid for crystals require no greater than the interpretation of a PA and lateral chest X-ray.

Societies Wishing to Survey: CAP

Societies Wishing to Comment: ACEP, ASCP, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
89060	50.2	12.1	16	60.6	6	0.2	1.9	6.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
89060	35021	50526	20.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
89060	4.6	5.5	0.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
89060		
	group practices	2.6
	internal medicine	7.2
	other nonphysician prov	40
	pathology	10.3
	rheumatology	36.9

Claims-Level Diagnosis Information:

CMD Comments

	ICD9	Pct of Time Used	ICD9 Descriptor
89060			
	274	1.9	GOUT
	714	2.7	RHEUMATOID ARTHRITIS AND OTHER INFLAMMATORY POLYARTHROPATHIES
	715	6.3	OSTEOARTHRITIS AND ALLIED DISORDERS
	716	2	OTHER AND UNSPECIFIED ARTHROPATHIES
	719	7.1	OTHER AND UNSPECIFIED DISORDERS OF JOINT
	726	1.1	PERIPHERAL ENTHESOPATHIES AND ALLIED SYNDROMES
	V72	4.8	SPECIAL INVESTIGATIONS AND EXAMINATIONS

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
89060								
	CMD	26		XXX		0.37		0.37

Harvard Data:

	Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
89060									
	CMD	0.37	0.37		1.00	1.00	1.00	0.16	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
89060									
	CMD	XXX							

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
89060										
	CMD									

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
89060										
	CMD				0.16	0.37				

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Other Medical and Therapeutic

The review of the other medical and therapeutic procedures primarily addressed comments submitted by the Carrier Medical Directors (CMDs) on codes that they felt were in most cases overvalued. Based on recommendations from the National Association of Medical Directors of Respiratory Care (NAMDRC), the American Thoracic Society (ATS), the American College of Chest Physicians (ACCP), the Joint Council of Allergy, Asthma and Immunology (JCAI), and the American Academy of Electrodiagnostic Medicine (AAEM), the RUC recommended maintaining the current values of most of the procedures that were identified by the CMDs. These recommendations were based on survey results, comparisons to final Harvard study results, comparisons to key reference services, and analysis of Medicare claims data.

The American Academy of Neurology (AAN) submitted a comment to HCFA on an EEG code, for which the RUC felt that AAN had provided enough compelling evidence to warrant increasing the RVU of the procedure. This recommendation was based on a survey 60 neurologists, comparisons to final Harvard study results, and comparisons to key reference services.

The Medical Oncology Association of Southern California, Inc., submitted recommendations on three chemotherapy codes for which the RUC recommended maintaining the current RVUs. These recommendations were based on the fact that one of the procedures had been recently reviewed by the RUC and the fact that the BMAD data showed that the other chemotherapy procedures are infrequently performed.

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Key (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality.

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
90900	Biofeedback, electromyogram	0.89	0.89	These codes were identified as overvalued by the CMDs. The CMDs commented that biofeedback is provided in a group setting, and that the actual patient encounter is 15 minutes.	The specialty society noted that the biofeedback codes 90900 and 90915 had never been surveyed before. APA-HCPAC noted that the use of biofeedback by a psychologist is part of integrated behavioral therapy coupled with a psychotherapy component. APA-HCPAC also noted that this procedure is not performed in a group setting and typically requires 50 minutes of individual face-to-face time. The specialty society noted that there seems to be some confusion between biofeedback training and biofeedback therapy. Based on their survey results, APA-HCPAC recommended an increased RVU of 1.95 for 90900 and 90915. Which represent the survey medians for both codes.	2
90915	Biofeedback, unspecified	0.89	0.89			

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
90902	Biofeedback, nerve impulse	0.89	0.43	These codes was identified as overvalued by the CMDs. The CMDs commented that biofeedback is provided in a group setting, and that the actual patient encounter is 15 minutes.	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe that a survey of practicing physicians would yield much useful information about these services. The specialty provided no compelling evidence to refute the CMD comment. Therefore, the RUC agreed to accept the proposed reduction of RVUs for these codes.	3
90904	Biofeedback, blood pressure	0.89	0.43			3
90906	Biofeedback, blood flow	0.89	0.43			3
90908	Biofeedback, brain waves	0.89	0.43			3
90910	Biofeedback, oculogram	0.89	0.43			3

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add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
90911	Anorectal biofeedback	2.15	2.15	This code was identified as overvalued by the CMDs. The CMDs believe that CPT code 90911[Biofeedback training; anorectal, including EMG and or manometry] does not have the intensity or time of 90937[Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription] or 90801[Psychiatric diagnostic interview examination including history, mental status, or disposition]. CPT code 46606[Anoscopy; with biopsy, single or multiple] requires less time, but is greater risk than 90911.	During anorectal biofeedback, the physician places into the anal canal an anal probe to measure anal sphincter pressure or electrical activity. This procedure can use manometry or EMG to measure sphincter activity. This procedure is lengthy taking at minimum 30 minutes, but typically lasting 45-60 minutes. For the patient this procedure is very uncomfortable particularly due to the length of time that the procedure requires. This procedure is more intense and requires more physician work than anoscopy (46606). This procedure is similar in its intensity to 90801 (psychiatric diagnostic interview examination). CPT code 90911 a was a new procedure that was added to the RBRVS in 1994. The RUC recommendation for this procedure was accepted by HCFA. Therefore, the RUC recommends maintaining the current value for this procedure.	2

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Key (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality.

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
91000	Esophageal intubation	0.99	0.73	The CMDs are unclear as to why 91000[Esophageal intubation and collection of washings for cytology, including preparation of specimens (separate procedure)] has a 50% greater RVUs than 89100[Duodenal intubation and aspiration; single specimen (eg, simple bile study or afferent loop culture) plus appropriate test procedure] or 89130[Gastric intubation, aspiration, diagnostic each specimen, for chemical analyses or cytopathology]. If these are the same tests (with 2 different CPT numbers), then the values should be the same. The CMDs do not believe that intubation with collection of washings is no more difficult than 93015 - cardiovascular stress test and is not as difficult as 99214 - a moderate level office visit code.	There was no request by the specialty to survey this procedure. Therefore the RUC recommends that the proposed reduction be accepted.	3

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Key (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality.

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
91010	Esophagus motility study	1.65	1.25	These codes were identified as potentially overvalued by the CMDs. The CMDs noted that the work and intensity of 91010, 91011, 91012, 91020, and 91030 is not as great as CPT code 99204[Office visit of moderate complexity]. The physician is allowed to code esophagoscopy (42300) with 91010, 91011, 91012, 91020, and 91030 if the esophageal pressure measuring device is placed during esophagoscopy. The interpretation of esophageal motility (91010,91011,91012), esophageal manometry (91020), and acid perfusion (91030), should be no more work than 78262[gastroesophageal reflux study (0.68)].	There was no request by the specialty to survey this procedure. Therefore, the RUC agreed to accept the proposed reduction of RVUs for these codes.	3
91011	Esophagus motility study	1.98	1.50			3
91012	Esophagus motility study	1.92	1.46			3
91020	Esophagogastric study	1.89	1.44			3
91030	Acid perfusion of the esophagus	1.20	0.91			3

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Key (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality.

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
91032	Esophagus, acid reflux test	1.59	1.21	CPT codes 91032 and 91033 were identified by the CMDs as potentially overvalued. The CMDs noted that the work and intensity of this procedure is not as great as CPT code 99204. The CMDs noted that a physician is allowed to code esophagoscopy (43200) with 91032 and 91033 if the ph electrode is placed during esophagoscopy. The interpretation of acid reflux should be no more than the interpretation of 78262[Gastroesophageal reflux study (0.68)]. The risk and work (less risk, more work) of 91032 and 91033 is similar to 36489[Percutaneous placement of a central venous catheter] and 90935[Hemodialysis procedure with single physician evaluation]. The CMDs recommended an RVU of 1.12 for code 91032 and 1.30 for 91033.	There was no request by the specialty to survey this procedure. Therefore, the RUC agreed to accept the proposed reduction of RVUs for codes 91032[Esophagus, acid reflux test, with intraluminal ph electrode for detection of gastroesophageal reflux] and 91033[Esophagus, acid reflux test, with intraluminal ph electrode for detection of gastroesophageal reflux; prolonged recording].	3
91033	Prolonged acid reflux test	1.71	1.30			3

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Key (1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality.

add = The code was not originally identified in the comments to HCFA. The RUC is requesting that it be added to the five year review.

Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
91052	Gastric analysis test	1.71	0.79	The CMDs noted that the work for 91052 is the same for 89135[Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); one hour]. Much of that work may be performed under the supervision of a physician rather than by a physician. It certainly does not require the mental work of 99204.	There was no request by the specialty to survey this procedure. Therefore, the RUC agreed to accept the proposed reduction of RVUs for these codes.	3
91055	Gastric intubation for smear	1.28	0.94	The CMDs noted that this code was not any different than 89135 or 89100, and should be reduced to 0.94.		3

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
91065	Breath hydrogen test	0.45	0.20	The CMDs do not believe that this is a physician test. They note that although the test takes three hours, this is not physician time. The patient takes, by mouth, lactose and then the expired helium is measured and compared to the baseline. The physician interpretation of this test is no greater than the physician interpretation of 96480 [Oxygen uptake, expired gas analysis; rest and exercise, direct, simple]. The expense of this test should be in the technical component and not the work RVUs.	There was no request by the specialty to survey this procedure. Therefore, the RUC agreed to accept the proposed reduction of RVUs for these codes.	3

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
94060	Evaluation of wheezing	0.31	0.31	In their comment letter to HCFA, the specialty society noted that currently the physician work units for 94375 and 94060 are valued at 0.31. The ATS contends that the work required for the bronchospastics evaluation is at least twice that required for the flow volume loop, and therefore, the RVU should be increased to 0.50	<p>The ATS noted that spirometric studies are most commonly plotted and presented as a flow volume loop. From the flow volume loop, vital capacity and flow rate can then be calculated. Since the bronchospastic examination requires <u>two flow volume loops</u>, plus the administration of a <u>bronchodilator</u>, there is significant increased intra-service time involved. The bronchospastic evaluation (94060) requires more physician time, skill and judgement in the interpretation of the test results. There is also stress concerning the side effects of the bronchodilator and post-service component of observation because of the loop alone.</p> <p>The RUC was concerned about the CPT descriptor of this procedure. They suggested that ATS propose a new code 94XXX [Bronchospasm evaluation with flow volume loops] that clearly illustrates that the procedure involves flow volume loops. The RUC would be comfortable recommending 0.50 if the code descriptor was revised. However, the procedure now indicates that this service is specifically related to spirometry and does not reflect the work that is described in the ATS comments. The RUC recommends maintaining the current value of 94060.</p>	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
94160	Vital capacity screening	0.18	0.18	The CMDs noted that the work of 94160 is less than 94010[Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurements(s), and/or maximal voluntary ventilation]. They also noted that the test can be performed using a hand held instrument.	The ACCP and ATS strongly recommend that codes 94150[Vital capacity, total(separate procedure)] and 94160[Vital capacity screening tests: total capacity, with timed forced expiratory volume (state duration), and peak flow rate] should be combined under the code <u>94160</u> . The vital capacity screening includes the 1) vital capacity measurement and 2) timed forced expiratory volume from which from which pulmonary flow are derived and 3) the peak flow rate. 94160 should be increased to an RVU of .20 In response to the CMD comment the ATS and ACCP also noted that this test is not done using a hand held instrument. The RUC agreed to maintain the current value of this code, based on the ATS presentation and survey data.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
94240	Residual lung capacity	0.26	0.26	The CMDs noted that this test is performed primarily by technicians. They also noted that this service requires less physician time than the interpretation of a PA/lateral chest x-ray CPT code 71020.	<p>The ATS noted that this test is used to measure lung volume. This procedure involves the risk of giving patients with emphysema 100% oxygen. This could result in loss of respiratory drive which increases the production of carbon dioxide. The ATS also reported that the survey results of 94240 indicate that the median RVU for this service is 0.26. Because this is the same physician RVU currently assigned to this procedure, ACCP and ATS are recommending that this RVU remain the same. No change is indicated. It was noted that the physician provides supervision and interpretation for this procedure.</p> <p>The RUC disagreed with the CMD recommendation to decrease the value of this code. In particular, the RUC took issue with the CMD contention that the service should be valued less than the interpretation of a PA/Lateral chest x-ray (CPT code 71020). The RUC agreed to maintain the current value.</p>	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
94350	Lung nitrogen washout curve	0.26	0.26	The CMDs noted that this test is performed primarily by technicians. They also noted that this service requires less physician time than the interpretation of a PA/lateral chest x-ray CPT code 71020.	<p>The specialty society reported that this test is used to measure lung volume. This procedure involves the risk of giving patients with emphysema 100% oxygen. This could result in loss of respiratory drive which increases the production of carbon dioxide. The ATS reported that the survey results of 94240 indicate that the median RVU for this service is .26. Because this is the same physician RVU currently assigned to this procedure, ACCP and ATS are recommending that this RVU remain the same. No change is indicated. It was noted that the physician provides supervision and interpretation for this procedure.</p> <p>The RUC agreed to maintain the current value of this code, based on the survey results and the fact that the CMDs did not have a full realization of the risk of this procedure.</p>	2
94360	Measure airflow resistance	0.26	0.26	The CMDs noted that this test is performed primarily by technicians. They also noted that this service requires less physician time than the interpretation of a PA/lateral chest x-ray CPT code 71020.	<p>The specialty society reported that this test is performed to measure lung resistance. It requires patients to sit in a body box. Approximately 10% of the patients will not comply. This test requires specialized equipment and must be performed in a sophisticated laboratory. ATS recommended that the RVU for this procedure be increased to 0.31 RVUs. It was noted that the physician provides supervision and interpretation for this procedure.</p> <p>Based on compelling evidence presented by the specialty society, the RUC disagreed with the CMD rationale to lower the RVU for this procedure, and recommended maintaining the current value.</p>	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
94375	Respiratory flow volume loop	0.31	0.31	The CMDs noted that a respiratory flow volume loop is now used for the majority of measurements of the values obtained under 94010. 94375[Respiratory flow volume loop] adds an inspiratory limb, the interpretation of which is relatively easy and does not add much work.	The specialty society recommends maintaining the current value for this procedure. It was noted that the physician provides supervision and interpretation for this procedure. The RUC agreed that the current value for this code be maintained, as it involves interpretation of more data than 94010.	2
94720	Monoxide diffusing capacity	0.26	0.26	The CMDs noted that this test is performed primarily by technicians. They also noted that this service requires less physician time than the interpretation of a PA/lateral chest x-ray CPT code 71020.	The specialty society reported that this test is used to measure how well the patient transfers oxygen from the air to blood. Carbon monoxide is used as the transfer agent in this test. This test is used in the evaluation of shortness of breath. The specialty society recommended an increased RVU for this procedure. It was noted that the physician provides supervision and interpretation for this procedure. Based on patient risk and the ATS survey results, the RUC disagreed with the CMD recommendation to lower the value of this procedure. They recommend maintaining the current value for this procedure.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
94725	Membrane diffusion capacity	0.26	0.26	The CMDs noted that this test is performed primarily by technicians. They also noted that this service requires less physician time than the interpretation of a PA/lateral chest x-ray CPT code 71020.	<p>The specialty society reported that this test is used to trace the pathway of an oxygen molecule to the red blood cell. This test is very complex and is not commonly performed. It is considered more difficult than 94720. The specialty society believes that this test is "grossly" undervalued at 0.26 RVUs. It was noted that the physician provides supervision and interpretation for this procedure.</p> <p>Based on the sophistication of the test and the ATS survey results, the RUC disagreed with the CMD recommendation to lower the value of this procedure. They recommend maintaining the current value for this procedure.</p>	2
94770	Exhaled carbon dioxide test	0.20	0.15	The CMDs noted that this test is performed primarily by technicians. They also noted that this service requires less physician time than the interpretation of a PA/lateral chest x-ray CPT code 71020.	<p>The specialty society noted that this test is a monitoring tool used to determine the placement of an endotracheal tube and the adequacy of mechanical ventilation. The recommended RVU is also the survey median for this code, which at 0.15 would represent a slight decrease in the RVUs for this code. It was noted that the physician provides supervision and interpretation for this procedure.</p> <p>The RUC agrees that this code is overvalued and recommended the ATS survey median of 0.15.</p>	3

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
95010	Sensitivity skin tests	0.15	0.15	The CMDs commented that this procedure is done by a nurse, and up to 30 tests are done per visit.	<p>The specialty society reported that this code is the allergy prick test, to determine patient sensitivity to drugs, venoms, or other biologicals. Usually seven tests are performed per visit not 30 as suggested by the CMDs. This test determines immediate reaction by the patient to these agents, and could result in anaphylaxis if the patient is extremely sensitive.</p> <p>The RUC felt that the specialty society presented compelling evidence to maintain the current value of the code. The RUC reviewed, and made a recommendation to HCFA on this procedure in 1993.</p>	2
95015	Sensitivity skin test	0.15	0.15	The CMDs commented that this procedure is done by a nurse, and up to 30 tests are done per visit.	<p>The specialty society reported that this code is the allergy intradermal test, to determine patient sensitivity to drugs, venoms, or other biologicals. Usually seven tests are performed per visit not 30 as suggested by the CMDs. This test determines immediate reaction by the patient to these agents, and could result in anaphylaxis if the patient is extremely sensitive.</p> <p>The RUC felt that the specialty society presented compelling evidence to maintain the current value of the code. The RUC reviewed, and made a recommendation on this procedure in 1993.</p>	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
95075	Ingestion challenge test	0.95	0.95	The CMDs commented that 95075[Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)] is most commonly performed to determine the effect of certain substances on the patient airway. The patient ingests a substance, is then asked to perform repetitive spirometry or flow volume loops. They feel that this procedure is analogous to 94070[Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after test dose of bronchodilator (aerosol only) antigen, exercise, cold air, methacholine or other chemical agent, with spirometry as in 94010].	<p>The specialty society reports that this code is used to test for allergic reaction to foods, drugs, or other substances. This procedure was never surveyed by Harvard. This test is done at the physician office and usually requires 30 minutes of face-to-face physician time. Unlike 94070 which takes 2 hours, this procedure requires 6-8 hours of physician monitoring. The specialty society has requested an increase in the RVU for this procedure.</p> <p>The RUC felt that the specialty society presented compelling evidence to maintain the current value of the code. The RUC reviewed, and made a recommendation on this procedure in 1993.</p>	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
95851	Range of motion measurements	0.28	0.16	The CMDs commented that measuring range of motion is the same physician work as interpreting a PA/Lateral chest x-ray CPT code 71020.	There was no request by the specialty to survey this procedure. Therefore, the RUC agreed to accept the proposed reduction of RVUs for these codes. The RUC agreed with the CMD recommendation to lower the value of this procedure.	3
95852	Range of motion measurements	0.19	0.11			3
95867	Muscle test, head or neck	0.62	0.79	The CMDs recommended an increase for this procedure code 95867[Needle electromyography, cranial nerve supplied muscles, unilateral] proportional to the decrease that they recommended for 95868[Needle electromyography, cranial supplied nerve muscles, bilateral]. This change was made so that the bilateral procedure 95868 is 150% of the unilateral procedure.	The AAEM supports the CMDs recommendation to increase the RVU of 95867 and decrease the RVU of 95868. Based on the CMD and the AAEM comments, the RUC agreed to the changes to these codes suggested by the CMDs.	1
95868	Muscle test, head or neck	1.50	1.18			3

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
95937	Neuromuscular junction test	0.60	0.65	The CMDs commented that the work, expertise, and intensity of 95937[Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method] does not equal 99213[Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity].	<p>The specialty society noted that this test involves a complex analysis of compound muscle action potential waveforms. These waveforms are analyzed with respect to amplitude and configuration and, sometimes area, following one or more trains of repetitive nerve stimulation. This procedure tests muscle weakness, and is also used to determine if the patient has myasthenia gravis. The specialty society reported that their survey respondents indicated that the work of performing this service has changed little over the past five years. AAEM also noted that overutilization of this code in the BMAD data may be reflective of miscoding of procedures.</p> <p>AAEM has requested an increased RVU for this procedure. Based on compelling evidence that was provided by AAEM the RUC recommends an increased RVU for this procedure code. The RUC noted that the Harvard value for this procedure is 0.77 and the Harvard time for this procedure is 29 minutes, which is twice the intra-service time of the reference procedure 99213 cited by the CMDs.</p>	1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
95951	EEG monitoring/video-record	3.80	6.00	In their public comment letter to HCFA the specialty society requested an increase in RVUs from 3.80 to 6.75 (this request was amended to 6.00 based on the results of their survey).	<p>Video recorded EEG is performed primarily on patients that are being considered for brain surgery in an attempt to alleviate the debilitating effects of intractable epilepsy. Video monitoring is precisely coordinated with EEG recordings in order to correlate behavioral changes with EEG changes. The physician is required to provide analysis and interpretation of each seizure which can take 15 to 45 minutes depending on location, duration and case complexity. The EEG correlation with clinical activity must be done on a second to second basis. Analysis of EEG data recorded over a 24 hour period, review of video recordings, and synthesis of the EEG data with which the video information and other clinical findings and observations takes an average of 60-90 minutes.</p> <p>Clinical symptoms such as aphasia, focal clonus, aversive posturing and behavioral changes provide clinical information that is not available with routine EEG (95819), ambulatory EEG (95950), or computerized EEG (95953). Physicians use this procedure to localize the seizure source, which is very important since this information determines which part of the temporal lobe will be removed. If the wrong part of the temporal lobe is removed the limbic system will be disabled resulting in severe brain damage.</p> <p>The RUC recommends increasing the RVU for this procedure from 3.8 to 6.0 based on the compelling evidence that the specialty society presented. The RUC agreed that this procedure requires a significant amount of physician time as patients undergoing a comprehensive epilepsy evaluation are most often monitored continuously. The RUC also agrees with the specialty society assertion that the physician work of this service is very intense. The specialty society noted in their presentation that providing this service is very stressful for the physician and requires a great deal of mental effort and judgement to use the data of the test to make a determination about the region of the brain to be removed at neurosurgery.</p>	1

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
96405	Intralesional chemo admin	0.52	0.52	In their comment letter to HCFA, the specialty society noted that CPT codes 96405[Chemotherapy administration, intralesional; up to and including 7 lesions] and CPT code 96406[Chemotherapy administration, intralesional; more than 7 lesions] are inappropriately valued because they are valued the same as the nonspecific intralesional injection codes 11900[Injection, intralesional; up to and including seven lesions] which has an RVU of 0.52 and 11901[Injection, intralesional; more than seven lesions] which has an RVU of 0.80.	These codes were reviewed by the RUC when they were introduced in 1993 and HCFA accepted the RUC recommendations. The specialty did not provide additional evidence, so the RUC recommends that the current RVUs be maintained.	2
96406	Intralesional chemo admin	0.80	0.80			2

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Code

	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
96440	Chemotherapy, intracavitary	2.37	2.37	In their public comment letter to HCFA, the Medical Oncology Association of Southern California, Inc., noted that the RVUs of CPT codes 96440[Chemotherapy administration into pleural cavity, requiring and including thoracentesis] and 96445[Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis] should be increased due to the increased amount of physician work involved.	Since fewer than 1,000 claims are submitted for these services annually, the RUC did not believe a survey of practicing physicians would yield much useful information about these services. The specialty society provided no compelling evidence to support their comment. Therefore, the RUC recommends maintaining the current RVUs for 96440 and 96445.	2
96445	Chemotherapy, intracavitary	2.20	2.20			2
96450	Chemotherapy, into CNS	1.89	1.89	This code was identified as undervalued in a public comment letter submitted by the Medical Oncology Association of Southern California. In a letter dated June 28, 1995 the American Society of Clinical Oncology (ASCO) asked that this code be recommended for no change.	ASCO conducted a survey of this code in 1992, and at that time HCFA accepted the RUC recommendation. Based on a recent RUC evaluation, the RUC recommended that the current value of this procedure be maintained.	2

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Code	Descriptor	95 RVU	RUC Rec RVU	Comment	Rationale	Key
98925	Osteopathic manipulation	0.45	0.45	The AOA comment recommended that these codes be included in the five year review, but proposed that the current RVUs be maintained.	Because the RVUs for these services are based directly on a survey as part of the Harvard RBRVS and they have also been through the a HCFA refinement panel, the RUC recommends that the current RVUs of these codes be maintained.	2
98926	Osteopathic manipulation	0.65	0.65			2
98927	Osteopathic manipulation	0.87	0.87			2
98928	Osteopathic manipulation	1.03	1.03			2
98929	Osteopathic manipulation	1.19	1.19			2

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**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90900 Global Period: _____ Current RVW: 0.89 Recommended RVW: 1.95

CPT Descriptor: Biofeedback training; by electromyogram application (eg, in tension headache, muscle spasm).

Source and Summary of Comment to HCFA on this service:

The comments from the Carrier Medical Director review process indicated their proposed reduction in the Relative Work Value for 90900 from 0.89 to 0.43. The present Work Value of 0.89 was provided to HCFA by Harvard, but was not based on survey data from psychologists who perform this service. The CMD comments suggest that 90900 is a service often provided in a group setting and that the actual encounter time with an individual patient may be comparable to a 15 minute hospital visit (99231) but considered the intensity of service to be less. Biofeedback procedures as typically provided by a psychologist are a behavioral medicine treatment modality integrated into a psychotherapy framework. This service is not typically provided in group settings and requires approximately 50 minutes of individual face-to-face encounter time. The American Psychological Association felt it appropriate to survey 90900 to determine research-based Relative Work Values for the service.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 47-year-old man, referred by his internist for biofeedback, has a chronic history of muscle spasms in the neck and shoulders, and tension-type diagnosed headaches. He has not responded well to a prior history of treatment with anti-anxiety medications and physical therapy.

Description of Pre-Service Work:

Preparing to see patient, preparation of biofeedback equipment, and review of records.

Description of Intra-Service Work:

History of problem and symptoms since last office visit and assessment of present physical symptoms and mental status. Assessment of treatment efficacy since last visit and review of assignments with patient (relaxation training log, daily pain/symptom index, etc.). Application of EMG biofeedback electrodes to target body region (eg, frontalis muscle). Patient guidance and instruction for integrating biofeedback stimulus and their physiological responses. Relaxation induction using patient-specific relaxation modality. Direct behavioral suggestions regarding symptom reduction and symptom management with interpretation of patient's present behavior and ability to change and control symptoms. Discussion of intersession assignments for target symptom management.

Description of Post-Service Work:

Arranging next visit. Documentation of services, including dictating report. Cleaning equipment and supplies. Communication with third party payors as necessary. Periodic telephonic consultation with referring physician, other professionals, and family for continuity of care. Review of new medical or lab studies when relevant.

SURVEY DATA:Specialty: American Psychological AssociationSample Size: 120¹ Response Rate (%): 26%(31) Median RVW: 1.9525th Percentile RVW: 1.71 75th Percentile RVW: 2.10 Low: .50 High: 5.18Median Pre-Service Time: 5 Min. Median Intra-Service Time: 50 Min.25th Percentile Intra-Svc Time: 45 Min. 75th Percentile Intra-Svc Time: 55 Min. Low: 30 High: 90

Median Post-Service Time:

	<u>Total Time</u>
Documentation of service provided	<u>10</u>
Arranging for further services	<u>5</u>
Reviewing results of studies	<u>5</u>
Communication further with patient, family, and other professionals including reports	<u>8</u>
Providing written or telephone reports to Medicare or other third party payors	<u>9</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99204	Office visit, moderate to high severity (45 minutes)	1.71
2)	99404	Preventive medicine counseling to an individual (approx 60 min)	1.95

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90900	5	50	37	3	4	3
99204	5	50	25	3	3	3
99404	5	50	18	2	2	2

¹The American Psychological Association sampled a total of 546 psychologists, of which 120 were targeted to this code.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The survey results support increasing the current RVW of 0.89 to 1.95 for 90900, and do not support the CMD recommendation to reduce the RVW to 0.43. The proposed reduction in value was based on comments suggesting that this service is typically performed in groups and involves only 15 minutes of face-to-face low intensity encounter. However, the survey respondents indicated a median intra-service time of 50 minutes and 94% rated the vignette as representing a typical patient. In addition, 79% of the sample reported increased work required to document the services provided, and 100% of the sample reported increased physician work and time in providing communication with 3rd party payors. The frequency of 90900 is relatively low, with 13,860 procedures reported by Medicare in 1994. At present, payment policy for 90900 reimburses for the procedure only when the procedure is used for a limited number of rehabilitative services, such as neuromuscular re-education. The use of biofeedback training for neuromuscular re-education would not typically be performed in groups. Although it is conceivable that in some settings biofeedback may be performed in groups, the service as performed by psychologists typically involves individual contact of substantially greater intensity and complexity than the CMD comments suggest. Should the RUC not adopt the current recommended RVW for 90900 it may indicate that referral to the CPT process is appropriate.

CMD Comments

06-Jul-95

Code: 90900

1995 RVUs: 0.89

Recommended RVUs: 0.43

Ratio: -0.52

Long Descriptor: Biofeedback training; by electromyogram application (eg, in tension headache, muscle spasm)

Reference Set (y/n): N Global Period: 000 Frequency: 14,136 Impact: -6502.56

Source: 1 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
90900			
	90853 SPECIAL GROUP THERAPY	0.43	XXX
	99231 SUBSEQUENT HOSPITAL CARE	0.51	XXX

CMD Comment:

Biofeedback is often provided in a group setting. The 1995 RVUs of 0.89 is excessive. The actual encounter time with an individual patient may be comparable to a 15 minute hospital visit (99231), but the intensity is less.

Societies Wishing to Survey: APA-HCPAC

Societies Wishing to Comment: AAPMR, APA, ASIM

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90900	21.1	3.3	22.1	42.4	27.9	1.5	0.6	4.3

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
90900	6155	13860	50.1

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90900	3.7	1.2	-1.2

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
90900		
	general surgery	4.4
	internal medicine	4.4
	neurology	6.1
	other nonphysician prov	5.9
	psychiatry	16.2
	psychology	6.8
	rehabilitation medicine	30.2

CMD Comments

06-Jul-95

urology	11.4
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Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
90900		
300	2.4	NEUROTIC DISORDERS
309	7.1	ADJUSTMENT REACTION
353	1.6	NERVE ROOT AND PLEXUS DISORDERS
354	2.2	MONONEURITIS OF UPPER LIMB AND MONONEURITIS MULTI- PLEX
722	2.4	INTERVERTEBRAL DISC DISORDERS
724	11.6	OTHER AND UNSPECIFIED DISORDERS OF BACK
728	13.9	DISORDERS OF MUSCLE, LIGAMENT, AND FASCIA
788	2.2	SYMPTOMS INVOLVING URINARY SYSTEM

Harvard Data:

Comm	Modif	Peckhv	Peck95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90900							
CMD		XXX	000	0.90	0.89	0.99	0.89

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
90900								
CMD	0.89	0.89	0.99	1.00	1.00	1.00	0.43	

Harvard Data:

Comm	Peck95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notatt	Imppt
90900								
CMD	000	0.90				42		10

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90900									
CMD									

Harvard Data:

CMD Comments

06-Jul-95

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfewk95	Sp	Phase	Twput	Iwput
90900									
CMD				0.43	0.89	py	n		0.017

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 90915 Global Period: _____ Current RVW: 0.89 Recommended RVW: 1.95

CPT Descriptor: Biofeedback (other)

Source and Summary of Comment to HCFA on this service:

The comments from the Carrier Medical Director review process indicated their proposed reduction in the Relative Work Value for 90915 from 0.89 to 0.43. The present Work Value of 0.89 was assigned by HCFA and was not based on survey data from psychologists who perform this service. The CMD comments suggest that 90915 is a service often provided in a group setting and that the actual encounter time with an individual patient may be comparable to a 15 minute hospital visit (99231) but considered the intensity of service to be less. Biofeedback procedures as typically provided by a psychologist are a behavioral medicine treatment modality integrated into a psychotherapy framework. This service is not typically provided in group settings and requires approximately 50 minutes of individual face-to-face encounter time. The American Psychological Association felt it appropriate to survey 90915 to determine research-based Relative Work Values for the service.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 35-year-old woman has a history of migraine headache, low back pain, irritable bowel syndrome, and cervical strain. She has been referred by her neurologist for biofeedback, with the statement that "primary diagnosis for treatment is unclear."

Description of Pre-Service Work:

Preparing to see patient, preparation of biofeedback equipment, and review of records.

Description of Intra-Service Work:

History of problem and symptoms since last office visit and assessment of present physical symptoms and mental status. Assessment of treatment efficacy since last visit and review of assignments with patient (relaxation training log, daily pain/symptom index, etc.). Application of biofeedback temperature sensor and/or EMG electrodes to target body regions (eg, finger tip, trapezius muscle, etc.). Patient guidance and instruction for integrating biofeedback stimulus and their physiological responses. Relaxation induction using patient-specific relaxation modality. Direct behavioral suggestions regarding symptom reduction and symptom management with interpretation of patient's present behavior and ability to change and control symptoms. Discussion of intersession assignments for target symptom management.

Description of Post-Service Work:

Arranging next visit. Documentation of services including dictating report. Cleaning equipment and supplies. Communication with third party payors as necessary. Periodic telephonic consultation with referring physician, other professionals, and family for continuity of care. Review of new medical or lab studies when relevant.

SURVEY DATA:Specialty: American Psychological AssociationSample Size: 120¹ Response Rate (%): 25%(30) Median RVW: 2.0325th Percentile RVW: 1.80 75th Percentile RVW: 2.29 Low: 1.00 High: 3.95Median Pre-Service Time: 8 Min. Median Intra-Service Time: 50 Min.25th Percentile Intra-Svc Time: 45 Min. 75th Percentile Intra-Svc Time: 60 Min. Low: 30 High: 90

Median Post-Service Time:	<u>Total Time</u>
Documentation of service provided	<u>8.5</u>
Arranging for further services	<u>5</u>
Reviewing results of studies	<u>5</u>
Communication further with patient, family, and other professionals including reports	<u>10</u>
Providing written or telephone reports to Medicare or other third party payors	<u>9.5</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99204	Office visit, moderate to high severity (45 minutes)	1.71
2)	99404	Preventive medicine counseling to an individual (approx 60 min)	1.95

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
90915	8	50	38	4	4	3
99204	5	45	17	3	3	3
99404	5	50	20.5	2	3	2

¹The American Psychological Association sampled a total of 546 psychologists, of which 120 were targeted to this code.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The survey results support increasing the current RVW of 0.89 to 1.95 for 90915, and do not support the CMD recommendation to reduce the RVW to 0.43. The proposed reduction in value was based on comments suggesting that this service is typically performed in groups and involves only 15 minutes of face-to-face low intensity encounter. However, the survey respondents indicated a median intra-service time of 50 minutes and 94% rated the vignette as representing a typical patient. In addition, 85% of the sample reported increased work required to document the services provided, and 100% of the sample reported increased physician work and time in providing communication with 3rd party payors. The frequency of 90915 is quite low, with only 5,056 procedures reported by Medicare in 1994. At present, payment policy for 90915 reimburses for the procedure only when the procedure is used for a limited number of rehabilitative services, such as neuromuscular re-education. The use of biofeedback training for neuromuscular re-education would not be performed in groups. Although it is conceivable that in some settings biofeedback may be performed in groups, the service as performed by psychologists typically involves individual contact of substantially greater intensity and complexity than the CMD comments suggest. Should the RUC not adopt the current recommended RVW of 1.95 for 90915, it may indicate that referral to the CPT process is appropriate.

CMD Comments

06-Jul-95

Code: 90915

1995 RVUs: 0.89

Recommended RVUs: 0.43

Ratio: -0.52

Long Descriptor: Biofeedback training; other

Reference Set (y/n): N

Global Period: 000

Frequency: 4,433

Impact: -2039.18

Source: 2

Year: 92

Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
90915			
	90853 SPECIAL GROUP THERAPY	0.43	XXX
	99231 SUBSEQUENT HOSPITAL CARE	0.51	XXX

CMD Comment:

Biofeedback is often provided in a group setting. The 1995 RVUS: of 0.89 are excessive. The actual encounter time with an individual patient may be comparable to a 15 minute hospital visit (99231), but the intensity is less.

Societies Wishing to Survey: APA-HCPAC

Societies Wishing to Comment: AAPM, AAPMR, ANA, APA, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
90915	32.3	9.4	4.1	67.7	20.5	0	0	1.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
90915	1680	5056	73.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
90915	4.7	1	-1.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
90915		
	general/family practice	4.7
	group practices	5.1
	internal medicine	2.1
	neurology	2.9
	obstetrics/gynecology	3
	psychiatry	39
	urology	37.5

CMD Comments

06-Jul-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
90915			
	296	2.4	AFFECTIVE PSYCHOSES
	298	3.9	OTHER NONORGANIC PSYCHOSES
	300	4.1	NEUROTIC DISORDERS
	599	1.8	OTHER DISORDERS OF URETHRA AND URINARY TRACT
	625	2	PAIN AND OTHER SYMPTOMS ASSOCIATED WITH FEMALE GENITAL ORGANS
	728	6.9	DISORDERS OF MUSCLE, LIGAMENT, AND FASCIA
	788	10.2	SYMPTOMS INVOLVING URINARY SYSTEM

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
90915								
	CMD			000		0.89		0.89

Harvard Data:

	Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
90915									
	CMD	0.89	0.89		1.00	1.00	1.00	0.43	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
90915									
	CMD	000							

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
90915										
	CMD									

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
90915										
	CMD				0.43	0.89				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 94160 Global Period: XXX Current RVW: .18 Recommended RVW: .2

CPT Descriptor: Vital capacity screening tests: total capacity, with timed forced expiratory volume and peak flow rate.

Source and Summary of Comment to HCFA on this service:
Carrier of Medical Directors

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 60 year old man with a history of chronic obstructive pulmonary disease (COPD) with chronic cough and shortness of breath is being evaluated as a new patient.

A 30 year old woman with a history of intermittent wheezing is being evaluated because of symptoms of shortness of breath.

Description of Pre-Service Work:

1. Explanation of procedure to patient and sometimes to other family members.
2. Explanation of the indications for doing the procedure.
3. Explanation of potential complications.

Description of Intra-Service Work:

Performing and monitoring the procedure.

Description of Post-Service Work:

1. Review and interpret results of procedure.
2. Explain implication of results to patient and sometimes other family members.
3. Discuss follow-up treatment options with patient and sometimes other family members.

SURVEY DATA:

Specialty: Pulmonary Medicine

Sample Size: 31 Response Rate (%): 50 Median RVW: .20

25th Percentile RVW: .16 75th Percentile RVW: .30 Low: .09 High: 2.40

Median Pre-Service Time: 4.0 mins Median Intra-Service Time: 5.0 mins

25th Percentile Intra-Svc Time: 4.0 75th Percentile Intra-Svc Time: 10.0 Low: 0 High: 30

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure:

5.0

ICU:

Other Hospital:

Office:

4.50

1.0

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	94375	Respiratory Flow Volume Loop	.31
2)			
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

This procedure is very similar to the pre, intra and post-service work involved in doing a respiratory flow volume loop. 94160 includes the measurement of the timed forced expiratory volume from which pulmonary flows are measured and/or a flow volume loop is measured. The same respiratory maneuvers are used and sometimes equipment is also used in 94375. 94160 is currently valued at .18 RVW's and 94375 is valued at .31 RVW's.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The ACCP and ATS strongly recommend that codes 94150 and 94150 should be combined under the code **94160**. The vital capacity screening includes the 1) vital capacity measurement and 2) timed forced expiratory volume from which from which pulmonary flow are derived and 3) the peak flow rate. 94160 should be increased to an RVW of .20.

CMD Comments

06-Jul-95

Code: 94160 1995 RVUs: 0.18 Recommended RVUs: 0.11 Ratio: -0.39

Long Descriptor: Vital capacity screening tests: total capacity, with timed forced expiratory volume (state duration), and peak flow rate

Reference Set (y/n): Y Global Period: XXX Frequency: 203,169 Impact: -14221.83

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
94160			
94010	BREATHING CAPACITY TEST	0.17	XXX
94690	EXHALED AIR ANALYSIS	0.07	XXX

CMD Comment:

The work of 94160 is actually less than 94010 (0.17) as the code requires only the total vital capacity, some timed forced expiratory volume and peak flow rate. 94010 includes the peak flow rate (although not stated), total spirometry, the timed vital capacity, and several expiratory flow rate measurements. The three values required for 94160 (total vital capacity, forced expiratory volume, and peak flow rate) can be obtained from a hand-held instrument.

Societies Wishing to Survey: ACCP, ATS

Societies Wishing to Comment: ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
94160	40	6.3	12.1	55.5	12.4	0.2	0.3	8.8

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
94160	196698	218628	5.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
94160	9.2	7.5	-0.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
94160		
	allergy	12
	cardiovascular disease	2.8
	general/family practice	13.8
	group practices	2.4
	internal medicine	22.3

CMD Comments

06-Jul-95

other nonphysician prov	3.2
pulmonary disease	38.1

Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
94160		
401	2.1	ESSENTIAL HYPERTENSION
466	1.5	ACUTE BRONCHITIS AND BRONCHIOLITIS
477	1.7	ALLERGIC RHINITIS
491	2.6	CHRONIC BRONCHITIS
492	1.1	EMPHYSEMA
493	6	ASTHMA
496	6.5	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
786	5.5	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
94160							
CMD			XXX		0.18		0.18

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amcod
94160								
CMD	0.18	0.18		1.00	1.00	1.00	0.11	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
94160								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
94160									
CMD									

Harvard Data:

CMD Comments

06-Jul-95

Comm	Svdoftd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
94160									
CMD				0.11	0.18				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 94240 Global Period: XXX Current RVW: .26 Recommended RVW: .26

CPT Descriptor: **Functional residual capacity or residual volume; helium method, nitrogen open circuit method, or other method.**

Source and Summary of Comment to HCFA on this service:
Carrier Medical Director

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 60 year old man with a history if chronic obstructive pulmonary disease (COPD) with chronic cough and shortness of breath is being evaluated as a new patient.

A 30 year old woman with a history of intermittent wheezing is being evaluated because of symptoms of shortness of breath.

Description of Pre-Service Work:

1. Explanation of procedure to patient and sometimes other family members.
2. Explanation of the indications for doing procedure.
3. Explanation of potential complications.

Description of Intra-Service Work:

Performing and monitoring the procedure.

Description of Post-Service Work:

1. Review and interpret results of procedure.
2. Explain implication of results to patient and sometimes other family members.
3. Discuss follow-up options with patient and sometimes other family members.

SURVEY DATA:

Specialty: Pulmonary Medicine

Sample Size: 31 Response Rate (%): 50 Median RVW: .26

25th Percentile RVW: .17 75th Percentile RVW: .35 Low: .05 High: 2.70

Median Pre-Service Time: 4.50 mins Median Intra-Service Time: 5.0 mins

25th Percentile Intra-Svc Time: 4.0 75th Percentile Intra-Svc Time: 13.50 Low: 0 High: .45

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure:

5.0

ICU:

Other Hospital:

Office:

5.50

1.0

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	94350	Determination of maldistribution of inspired gas; multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time.	.26
2)			
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre, intra, and post-service time and intensity of 94250 is quite similar to that of reference service 94350.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The findings of our survey of 94240 indicate that the median RVW for this service is .26. Because this is the same physician RVW currently assigned to this procedure, ACCP and ATS are recommending that this RVW remain the same. No change is indicated.

CMD Comments

06-Jul-95

Code: 94240

1995 RVUs: 0.26

Recommended RVUs: 0.16

Ratio: -0.38

Long Descriptor: Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method

Reference Set (y/n): N Global Period: XXX Frequency: 251,388 Impact: -25138.8

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
94240			
	71020 CHEST X-RAY	0.22	XXX

CMD Comment:

This test is principally done in almost all cases today by a technician. The interpretation of this test requires less expertise and time and certainly does not involve any more risk or as much risk as the interpretation of a PA and lateral chest X-ray.

Societies Wishing to Survey: ACCP, ATS

Societies Wishing to Comment: ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
94240	38.7	4.9	10.5	49.7	10.7	0.2	0.7	8.6

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
94240	231681	271208	8.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
94240	30.5	26.9	-1.8

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
94240		
	cardiovascular disease	2.4
	group practices	5
	internal medicine	16.8
	other nonphysician prov	2
	pulmonary disease	67.7

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
94240		
428	1	HEART FAILURE
491	1.7	CHRONIC BRONCHITIS
492	1.2	EMPHYSEMA
493	2.1	ASTHMA
496	6.3	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
518	1.3	OTHER DISEASES OF LUNG
786	8.9	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
94240							
CMD			XXX		0.26		0.26

Harvard Data:

Comm	Mfswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
94240								
CMD	0.26	0.26		1.00	1.00	1.00	0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
94240								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
94240									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
94240									
CMD				0.16	0.26				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 94350 Global Period: XXX Current RVW: .26 Recommended RVW: .25

CPT Descriptor: Determination of maldistribution of inspired gas; multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time.

Source and Summary of Comment to HCFA on this service: Carrier Medical Directors

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 60 year-old man with history of chronic obstructive pulmonary disease (COPD) with chronic cough and shortness of breath is being evaluated as a new patient.

A 30 year-old woman with a history of intermittent wheezing is being evaluated because of symptoms of shortness of breath.

Description of Pre-Service Work:

- 1) Explanation of procedure to the patient and sometimes family members.
- 2) Explanation of indications for performing the procedure to the patient and sometimes family members.
- 3) Explanation of potential complications to the patient and sometimes family members.

Description of Intra-Service Work:

Performance and monitoring of the procedure.

Description of Post-Service Work:

- 1) Review and interpretation of the results of the procedure.
 - 2) Explanation of the implications of the results to the patient and sometimes family members.
 - 3) Discuss follow-up treatment options with patient and other family members.
-

SURVEY DATA:

Specialty: Pulmonary Medicine

Sample Size: 30 Response Rate (%): 49 Median RVW: .25

25th Percentile RVW: .18 75th Percentile RVW: .40 Low: .10 High: 2.40

Median Pre-Service Time: 4.50 min Median Intra-Service Time: 7.5 min

25th Percentile Intra-Svc Time: 2.25 min 75th Percentile Intra-Svc Time: 15.00 min Low: 0 High: 45 min

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure:

5.0

ICU:

n/a

n/a

Other Hospital:

n/a

n/a

Office:

5.0

1.0

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	94240	Residual Lung Capacity	.26
2)			
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre-, intra-, and post-service time and the intensity of 94350 and reference service 94240 are nearly identical.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The RVW that is currently assigned to the code, .26, is nearly identical to the RVW extrapolated from our survey data. Therefore, the ATS and the ACCP recommend no change in the RVW for CPT Code 94350.

CMD Comments

06-Jul-95

Code: 94350 **1995 RVUs:** 0.26 **Recommended RVUs:** 0.16 **Ratio:** -0.38

Long Descriptor: Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 48,430 **Impact:** -4843

Source: 2 **Year:** 92 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
94350			
	71020 CHEST X-RAY	0.22	XXX

CMD Comment:

This test is principally done in almost all cases today by a technician. The interpretation of this test requires less expertise and time and certainly does not involve any more risk or as much risk as the interpretation of a PA and lateral chest X-ray.

Societies Wishing to Survey: ACCP, ATS

Societies Wishing to Comment: ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
94350	39.9	5.8	12	51.3	10.2	0.1	0.5	3.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
94350	47717	52784	5.2

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
94350	27	24.1	-1.5

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
94350		
	allergy	2.4
	cardiovascular disease	3.3
	general/family practice	2.9
	group practices	4.5
	internal medicine	18.9
	other nonphysician prov	6.7
	pulmonary disease	58.6

CMD Comments

06-Jul-95

Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
94350		
491	2.5	CHRONIC BRONCHITIS
492	1.1	EMPHYSEMA
493	2.5	ASTHMA
496	6.2	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
786	10.3	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
94350							
CMD			XXX		0.26		0.26

Harvard Data:

Comm	Mewk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
94350								
CMD	0.26	0.26		1.00	1.00	1.00	0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
94350								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
94350									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
94350									
CMD				0.16	0.26				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 94360 Global Period: XXX Current RVW: .26 Recommended RVW: .31

CPT Descriptor: Determination of resistance to airflow, oscillatory or plethysmographic methods.

Source and Summary of Comment to HCFA on this service: Carrier Medical Directors

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 60 year-old man with history of chronic obstructive pulmonary disease (COPD) with chronic cough and shortness of breath is being evaluated as a new patient.

A 30 year-old woman with a history of intermittent wheezing is being evaluated because of symptoms of shortness of breath.

Description of Pre-Service Work:

- 1) Explanation of procedure to the patient and sometimes family members.
- 2) Explanation of indications for performing the procedure to the patient and sometimes family members.
- 3) Explanation of potential complications to the patient and sometimes family members.

Description of Intra-Service Work:

Performance and monitoring of the procedure.

Description of Post-Service Work:

- 1) Review and interpretation of the results of the procedure.
- 2) Explanation of the implications of the results to the patient and sometimes family members.
- 3) Discuss follow-up treatment options with patient and other family members.

SURVEY DATA:

Specialty: Pulmonary Medicine

Sample Size: 30 Response Rate (%): 49 Median RVW: .31

25th Percentile RVW: .22 75th Percentile RVW: .55 Low: .05 High: 2.0

Median Pre-Service Time: 5.0 min Median Intra-Service Time: 10.0 min

25th Percentile Intra-Svc Time: 5.0 min 75th Percentile Intra-Svc Time: 20.0 min Low: 0 High: 45.0 min

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure:

5.0 min

ICU:

n/a

n/a

Other Hospital:

n/a

n/a

Office:

8.0 min

1.0

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	94375	Respiratory Flow Volume Loop	.31
2)	94400	CO ₂ Breathing Response Curve	.40
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre-, intra-, and post-service time and the intensity of 94360 is quite similar to both reference service 94375 and reference service 94400.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The measurement of lung resistance is a very complex procedure only performed in the most sophisticated laboratories. It requires the use of specialized equipment, including a body box. We recommend that the RVW be increased from .26 to a minimum of .31, the current RVW of 94375, in light of the highly complicated nature of the test.

CMD Comments

06-Jul-95

Code: 94360

1995 RVUs: 0.26

Recommended RVUs: 0.16

Ratio: -0.38

Long Descriptor: Determination of resistance to airflow, oscillatory or plethysmographic methods

Reference Set (y/n): N Global Period: XXX Frequency: 30,457 Impact: -3045.7

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
94360			
	71020 CHEST X-RAY	0.22	XXX

CMD Comment:

This test is principally done in almost all cases today by a technician. The interpretation of this test requires no less expertise or time and certainly does not involve any more risk or as much risk as the interpretation of a PA and lateral chest X-ray.

Societies Wishing to Survey: ACCP, ATS

Societies Wishing to Comment: ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
94360	34.9	5.5	11.2	46.5	12.9	0	0.9	20.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
94360	23615	32246	16.9

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
94360	23	20.4	-1.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
94360		
	cardiovascular disease	2.4
	group practices	4.1
	internal medicine	11.8
	other nonphysician prov	4.5
	pulmonary disease	68.9

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

	ICD9	Pct of Time Used	ICD9 Descriptor
94360			
	491	1.2	CHRONIC BRONCHITIS
	492	1.4	EMPHYSEMA
	493	2.7	ASTHMA
	496	6.8	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
	515	1	POSTINFLAMMATORY PULMONARY FIBROSIS
	518	2.5	OTHER DISEASES OF LUNG
	780	1.3	GENERAL SYMPTOMS
	786	9.3	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
94360							
CMD			XXX		0.26		0.26

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
94360								
CMD	0.26	0.26		1.00	1.00	1.00	0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
94360								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
94360									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
94360									
CMD				0.16	0.26				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS

FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 94375 Global Period: XXX Current RVW: .31 Recommended RVW: .31

CPT Descriptor: Respiratory Flow Volume Loop

Source and Summary of Comment to HCFA on this service: Carrier Medical Directors

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 60 year-old man with history of chronic obstructive pulmonary disease (COPD) with chronic cough and shortness of breath is being evaluated as a new patient.

A 30 year-old woman with a history of intermittent wheezing is being evaluated because of symptoms of shortness of breath.

Description of Pre-Service Work:

- 1) Explanation of procedure to the patient and sometimes family members.
- 2) Explanation of indications for performing the procedure to the patient and sometimes family members.
- 3) Explanation of potential complications to the patient and sometimes family members.

Description of Intra-Service Work:

Performance and monitoring of the procedure.

Description of Post-Service Work:

- 1) Review and interpretation of the results of the procedure.
- 2) Explanation of the implications of the results to the patient and sometimes family members.
- 3) Discuss follow-up treatment options with patient and other family members.

SURVEY DATA:

Specialty: Pulmonary Medicine

Sample Size: 30 Response Rate (%): 49 Median RVW: .31

25th Percentile RVW: .17 75th Percentile RVW: .37 Low: .06 High: 1.50

Median Pre-Service Time: 5.0 Median Intra-Service Time: 6.50

25th Percentile Intra-Svc Time: 2.0 75th Percentile Intra-Svc Time: 10.0 Low: 0 High: 30

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>5.0</u>	
ICU:	<u>n/a</u>	<u>n/a</u>
Other Hospital:	<u>n/a</u>	<u>n/a</u>
Office:	<u>6.0</u>	<u>1.0</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	94060	Evaluation of Wheezing	.31
2)			
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre-, intra-, and post-service time and the intensity of 94375 is quite similar to reference service 94060.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

The current RVW, .31, is identical to the RVW that we are recommending as substantiated by our data. The ATS and ACCP recommend that the RVW for CPT code 94375 remain at .31.

CMD Comments06-Jul-95

Code: 94375

1995 RVUs: 0.31

Recommended RVUs: 0.19

Ratio: -0.39

Long Descriptor: Respiratory flow volume loop

Reference Set (y/n): N Global Period: XXX Frequency: 413,396 Impact: -49607.52

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
94375			
	94010 BREATHING CAPACITY TEST	0.17	XXX

CMD Comment:

A respiratory flow volume loop is now used for the majority of measurements of the values obtained under 94010. This adds an inspiratory limb, the interpretation of which is relatively easy and does not add much work and adds almost no additional time.

Societies Wishing to Survey: ACCP, ATS

Societies Wishing to Comment: ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
94375	40.4	6.2	14	53.4	11.9	0.3	0.5	6.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
94375	343769	442420	13.4

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
94375	16	14.7	-0.7

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
94375		
	allergy	3
	cardiovascular disease	3.2
	general/family practice	12.3
	group practices	2.5
	internal medicine	23.5
	other nonphysician prov	3.4
	pulmonary disease	46.9

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
94375		
401	1.8	ESSENTIAL HYPERTENSION
414	1.1	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
466	1.1	ACUTE BRONCHITIS AND BRONCHIOLITIS
491	2.7	CHRONIC BRONCHITIS
492	1.1	EMPHYSEMA
493	3.8	ASTHMA
496	7.6	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
786	7.8	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
94375							
CMD			XXX		0.31		0.31

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amecod
94375								
CMD	0.31	0.31		1.00	1.00	1.00	0.19	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
94375								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
94375									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
94375									
CMD				0.19	0.31				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 94720 Global Period: XXX Current RVW: .26 Recommended RVW: .31

CPT Descriptor: Monoxide Diffusing Capacity

Source and Summary of Comment to HCFA on this service: Carrier Medical Directors

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 60 year-old man with history of chronic obstructive pulmonary disease (COPD) with chronic cough and shortness of breath is being evaluated as a new patient.

A 30 year-old woman with a history of intermittent wheezing is being evaluated because of symptoms of shortness of breath.

Description of Pre-Service Work:

- 1) Explanation of procedure to the patient and sometimes family members.
- 2) Explanation of indications for performing the procedure to the patient and sometimes family members.
- 3) Explanation of potential complications to the patient and sometimes family members.

Description of Intra-Service Work:

Performance and monitoring of the procedure.

Description of Post-Service Work:

- 1) Review and interpretation of the results of the procedure.
- 2) Explanation of the implications of the results to the patient and sometimes family members.
- 3) Discuss follow-up treatment options with patient and other family members.

SURVEY DATA:

Specialty: Pulmonary Medicine

Sample Size: 19 Response Rate (%): 53 Median RVW: .31

25th Percentile RVW: .20 75th Percentile RVW: .40 Low: .05 High: 1.50

Median Pre-Service Time: 4.0 Median Intra-Service Time: 8.50

25th Percentile Intra-Svc Time: 4.25 75th Percentile Intra-Svc Time: 13.75 Low: 0 High: 30

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure:

5.0

ICU:

n/a

n/a

Other Hospital:

n/a

n/a

Office:

5.0

1.0

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	94375	Respiratory Flow Volume Loop	.31
2)	94400	CO ₂ Breathing Response Curve	.40
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre-, intra-, and post-service time and the intensity of 94720 is quite similar to reference service 94400 and is more complex than reference service 94375.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Monoxide diffusing capacity is a very complex test that exceeds 94375 (Respiratory flow volume loop) in its complexity. 94375 has a RVW of .31, whereas the current RVW for this test is only .26. Therefore we recommend, at a minimum, an RVW that is in line with 94375, or .31.

CMD Comments

06-Jul-95

Code: 94720

1995 RVUs: 0.26

Recommended RVUs: 0.16

Ratio: -0.38

Long Descriptor: Carbon monoxide diffusing capacity, any method

Reference Set (y/n): N Global Period: XXX Frequency: 285,336 Impact: -28533.6

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
94720			
	71020 CHEST X-RAY	0.22	XXX

CMD Comment:

This test is principally done in almost all cases today by a technician. The interpretation of this test requires less expertise and time and certainly does not involve any more risk or as much risk as the interpretation of a PA and lateral chest X-ray.

Societies Wishing to Survey: ACCP, ATS

Societies Wishing to Comment: ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
94720	37.6	4.5	10.2	49	11.3	0.2	0.7	8.7

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
94720	265095	309670	8.1

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
94720	28.8	25.1	-1.9

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
94720		
	cardiovascular disease	2
	group practices	5.1
	internal medicine	16.3
	pulmonary disease	70.1

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
94720			

CMD Comments

06-Jul-95

491	1.6	CHRONIC BRONCHITIS
492	1.2	EMPHYSEMA
493	2.1	ASTHMA
496	6	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
518	1.3	OTHER DISEASES OF LUNG
786	9.1	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
94720							
CMD			XXX		0.26		0.26

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
94720								
CMD	0.26	0.26		1.00	1.00	1.00	0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
94720								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
94720									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
94720									
CMD				0.16	0.26				

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 94725 Global Period: XXX Current RVW: .26 Recommended RVW: .33

CPT Descriptor: Membrane Diffusing Capacity

Source and Summary of Comment to HCFA on this service: Carrier Medical Directors

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 60 year-old man with history of chronic obstructive pulmonary disease (COPD) with chronic cough and shortness of breath is being evaluated as a new patient.

A 30 year-old woman with a history of intermittent wheezing is being evaluated because of symptoms of shortness of breath.

Description of Pre-Service Work:

- 1) Explanation of procedure to the patient and sometimes family members.
- 2) Explanation of indications for performing the procedure to the patient and sometimes family members.
- 3) Explanation of potential complications to the patient and sometimes family members.

Description of Intra-Service Work:

Performance and monitoring of the procedure.

Description of Post-Service Work:

- 1) Review and interpretation of the results of the procedure.
 - 2) Explanation of the implications of the results to the patient and sometimes family members.
 - 3) Discuss follow-up treatment options with patient and other family members.
-

SURVEY DATA:

Specialty: Pulmonary Medicine

Sample Size: 30 Response Rate (%): 49 Median RVW: .33

25th Percentile RVW: .20 75th Percentile RVW: .41 Low: .09 High: 2.0

Median Pre-Service Time: 5.0 Median Intra-Service Time: 8.0

25th Percentile Intra-Svc Time: 3.0 75th Percentile Intra-Svc Time: 15.0 Low: 0 High: 30

Median Post-Service Time:

Total Time

Number of Visits

Day of Procedure:

5.0

ICU:

n/a

n/a

Other Hospital:

n/a

n/a

Office:

4.0

1.0

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	94720	Monoxide diffusing Capacity	.26
2)	94400	CO ₂ Breathing Response Curve	.40
3)			
4)			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre-, intra-, and post-service time and the intensity of 94725 is quite similar to reference service 94400 and is more complex than reference service 94720.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

This is a very complex test that is uncommonly performed. It involves measuring the diffusing capacity at least twice. With a current RVW at only .26 it is grossly undervalued and merits an increase. The ATS and ACCP recommend an RVW of .33 as substantiated by our data. It should be noted, however, that this test is performed in only the most sophisticated laboratories and, as such, our survey respondents may not have been familiar with the complexities of the test and thus, may have undervalued it to some extent.

CMD Comments

06-Jul-95

424	1.2	OTHER DISEASES OF ENDOCARDIUM
428	1.2	HEART FAILURE
440	1.3	ATHEROSCLEROSIS
491	4	CHRONIC BRONCHITIS
493	2.1	ASTHMA
496	3.7	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
786	15.4	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
94725							
CMD			XXX		0.26		0.26

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
94725								
CMD	0.26	0.26		1.00	1.00	1.00	0.16	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	imppt
94725								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
94725									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
94725									
CMD				0.16	0.26				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95010 Global Period: XXX Current RVW: 0.15 Recommended RVW: 0.70

CPT Descriptor: Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests

Source and Summary of Comment to HCFA on this service:

CMDs have recommended a decrease in the RWV to 0.07. Our median RVW survey results indicate a value of 0.70.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old male inpatient with a history of skin rash, possibly urticarial, after taking penicillin and worsening of asthma after being given Ceftin, developed subacute bacterial endocarditis. Patient is seen by infectious disease consultant who recommends penicillin as the most suitable drug and you are asked to evaluate the patient for penicillin allergy.

Description of Pre-Service Work: Determination of which antibiotic is to be tested, determination of risk factors for safe testing, i.e., cardiac disease, beta blocker presence. Ordering appropriate test materials, including appropriate dilutions of drugs. Obtaining informed consent from patient. Explaining all risks, including anaphylaxis and treatment for ana-phyllaxis. Preparation of materials for treatment of anaphylaxis.

Description of Intra-Service Work: Apply prick/puncture type tests (usually three) sequentially every 20 minutes. Observe patient for development of positive skin test and possible anaphylaxis. If test is positive, prepare schedule for oral desensitization. If test is negative, write orders for administration of penicillin. Physician should be present in room for entire intra-service period to observe for presence of anaphylaxis.

Description of Post-Service Work: Write or dictate procedural report.

SURVEY DATA:

Specialty: Joint Council of Allergy, Asthma and Immunology

Sample Size: 55 Response Rate (%): 61.82 Median RVW: 0.70

25th Percentile RVW: 0.20 75th Percentile RVW: 1.60 Low: 0.04 High: 2.76

Median Pre-Service Time: 10 Median Intra-Service Time: 25

25th Percentile Intra-Svc Time: 17.5 75th Percentile Intra-Svc Time: 47.5 Low: 1 High: 150

Median Post-Service Time / Day of Procedure: 5

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), and/or maximal voluntary ventilation.	0.17
95180	Rapid desensitization procedure, each hour (eg, insulin, penicillin, horse serum).	2.01
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and, medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.	1.84

Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

COMMENTS ON CHOICE OF REFERENCE SERVICES

94010 describes a pulmonary function study to obtain baseline pulmonary function readings. It involves a relatively short period of time on the part of the physician who needs to insure that the equipment has been calibrated and that the technician is familiar with the procedure for doing pulmonary function testing. The duration of physician work involved in 94010 is about the same amount that is involved in doing a single prick puncture test for drug, biologic or venom.

95180 describes hourly physician work in desensitization to penicillin or other anti-biotics, or drugs, e.g. insulin. It is a procedure which carries great mental stress because of the risk of anaphylaxis. It also requires determination of which drug dose is a safe starting dose and what incremental challenge amount should be given at each sequential challenge. It involves careful observation by the physician of the patient for 15-30 minutes after each dosage to determine if there has been a reaction. The physician must then assess whether it is safe to proceed to the next dosage level. The risk for this code is substantially higher for this test than for prick/puncture testing.

99222 involves an approximate 50 minute visit of a physician to a newly admitted patient to the hospital. It requires a comprehensive history and physical examination and medical decision making of moderate complexity. The magnitude of physician work for this code is substantially greater than for the testing, but the physician time involved in total is the same for both the surveyed and the reference code.

DESCRIPTION OF THE PHYSICIAN WORK COMPONENTS**A. PRE-SERVICE WORK**

Pre-Service Work Clinical Description: Median Pre-Service Time (min.): 10 min.

The work pre-service will vary if the test allergen is a venom or biologic where test protocols already exist which include recommended concentrations of test materials. If a test item is a drug, then the physician will

not only have to determine the nature and severity of the previous drug reaction, but whether the test drug is the same to which the patient reacted or an analog where the risk may be somewhat less depending on the degree of cross reactivity. Physicians will have to determine the amounts of cross reactivity. The physician will have to determine probable safe starting test doses for the prick/puncture tests.

In addition, the physician will need to take a history and perform a physical examination to insure that the patient's critical status on the day of testing will make testing safe. In particular, the physician must insure that the patient does not take any drugs that will interfere (antihistamine) with or contraindicate (beta blocker) testing. If the patient has asthma, the physician will need to insure that the pulmonary status is sufficiently stable to allow for safe testing. A physical examination is necessary to establish a baseline should there be a systemic symptom as a result of testing.

Finally, the patient will have to be fully informed of the risks of testing, including anaphylaxis; consent must be obtained. Since the determination of safe test doses and obtaining informed consent is only done once, the total time involved in all these procedures is about 30 minutes. Most protocols for three test doses - the time for these procedures should be divided equally among all three tests.

While the carrier medical directors suggest the average number of prick/puncture tests is 30 and drug, biologic and venom testing, our data show it to be much closer to 3.

Comparison to Reference Service(s) Including Pre-Service Work Time and Intensity:

The total physician time and pre-service spirometry is approximately the same as in pre-service prick/puncture testing, but the risk of anaphylaxis and the need to obtain a much more detailed consent is substantially greater, therefore the values for spirometry is equal to that of single prick/puncture test. The total time in 95180 - rapid desensitization - is about the same as in prick/puncture testing, since rapid desensitization involves selection proper dose of antigens to start the desensitization and the obtaining of informed consent of the same nature. The pre-service work of an initial hospital visit involves the review of prior medical records when available and probably involves the same amount of work as prick/puncture testing.

B. Intra-Service Work

Intra-Service Work Clinical Description: Median Intra-Service Time (min.): 25 min.

The proper application of the test takes 5 minutes and the patient is then observed for 20 minutes to determine whether there is a skin reaction. At the same time, the patient must be constantly observed for the development of systemic reactivity. The total average number of tests is 3, so the total testing time is 75 minutes since these tests are done sequentially.

Comparison to Reference Service(s) Including Intra-Service Work Time and Intensity

Intra-service work in prick/puncture testing is much more stressful than in pulmonary function testing because of the continuing need to access for the presence of systemic anaphylactic reaction and the need to be ready to treat this once it occurs. It also requires the proper skill in reading the skin reactivity. The intra-service work would be equal to the intra-service work in rapid desensitization, but on a per test basis - would be for a much shorter period. The amount of work in a level 2 - initial hospital admission - would be similar in time, but the initial hospital visit would probably be more complex in medical decision making as well as involving a more extensive history and physical examination.

C. POST-SERVICE WORK

Post-Service Work Clinical Description: Median Post-Service Time (min.) 5 min.

The main post-service work involves insuring that the patient is assessed for any reaction and determining whether it is safe to continue with intra-cutaneous tests if prick/puncture tests where negative.

Comparison to Reference Service Including Post-Service Work Time and Intensity:

The amount of post-service work in time and intensity is approximately equal to that of pulmonary function testing and rapid desensitization and might be less than the extent of the therapy initiating process associated with initial hospitalizations.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Please see above.

CMD Comments

06-Jul-95

Code: 95010

1995 RVUs: 0.15

Recommended RVUs: 0.07

Ratio: -0.53

Long Descriptor: Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 46,534 **Impact:** -3722.72

Source: 8 **Year:** 93 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
95010			
	93510 LEFT HEART CATHETERIZATION	4.33	000

CMD Comment:

This code allows for the billing of number of tests done per visit. The average number of tests done per visit from our data is 30 tests with RVUs of 0.15 for each scratch test (done commonly by the nurse). The total RVUs for that service are 4.50. This would relate to a little more than the reference code 36215 and would be 0.17 RVUs greater than the reference code 93510. Neither of these latter procedures are done "incident to" and both require greater intensity and skill. Reducing the RVUs to 0.07 per service, reduces the average total RVUs to 2.10. Which is approximately the mid- point between reference codes 99204 and 99205. Even at that, the service could still be overvalued.

Societies Wishing to Survey: AAO-HNS, JCAI

Societies Wishing to Comment: AAD, ACCP, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
95010	33.3	1.2	12.7	87.4	17.1	0	0.3	7.2

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
95010	.	32978	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
95010	.	1.9	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
95010		
	allergy	64
	general/family practice	7.3
	internal medicine	18.2
	otolaryngology	2.8
	pediatrics	3.1

CMD Comments

06-Jul-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
95010			
	443	1.3	OTHER PERIPHERAL VASCULAR DISEASE
	466	2.5	ACUTE BRONCHITIS AND BRONCHIOLITIS
	477	13.8	ALLERGIC RHINITIS
	493	5.5	ASTHMA
	692	3.9	CONTACT DERMATITIS AND OTHER ECZEMA
	693	1.3	DERMATITIS DUE TO SUBSTANCES TAKEN INTERNALLY
	786	1.5	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS
	995	3.7	CERTAIN ADVERSE EFFECTS NOT ELSEWHERE CLASSIFIED

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
95010							
CMD			XXX		0.15		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
95010								
CMD	0.15	0.15			1.00	1.00	0.07	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
95010								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
95010									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
95010									

CMD Comments

06-Jul-95

CMD	0.07	0.15
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**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95015 Global Period: XXX Current RVW: 0.15 Recommended RVW: 0.70

CPT Descriptor: Intracutaneous (intra dermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, specify number of tests

Source and Summary of Comment to HCFA on this service:

CMDs have recommended a decrease in the RVW to 0.07. Our median RVW survey results indicate a value of 0.70.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year old male is stung by an unknown stinging insect while mowing his back yard. He has been stung before without reaction. Within 30 minutes he develops generalized urticaria, throat tightening and some transient difficulty in breathing. He is brought to an emergency room and appropriately treated. He is then referred by his primary care physician to you for testing.

Description of Pre-Service Work: Informed consent is obtained for testing, patient warned of risks of anaphylaxis. Risk factors for testing are determined, including asthma history, cardiovascular history, and presence of beta blockers. Seven prick/puncture tests including positive and negative controls are applied. All tests are negative except for positive control.

Description of Intra-Service Work: Sequentially stronger intracutaneous tests to honeybee, white and yellow-faced hornet, yellow jacket and wasp are applied. Patient develops wheal 12 mm and flare 35 mm to yellow jacket at 0.01 mcg/ml concentration and 15 mm wheal and 28 mm flare to white-faced hornet at 0.1 mcg/ml concentration. All other tests are negative. A total of 17 intracutaneous tests are applied. Each test set is five or fewer (fewer if patient reacted to lower concentration of test material) and each test set takes ten minutes to apply. The patient is then observed for ten minutes for positive test and/or for the development of anaphylaxis. Physician is prepared to treat anaphylaxis. Physician determines safety to apply next set of skin tests.

Description of Post-Service Work: Patient is informed of positive tests and recommendations made for 1) venom immunotherapy for a minimum of five years, 2) risks and benefits of immunotherapy explained, 3) alternative therapy if no immunotherapy but carrying Epi-pen explained to patient, 4) patient instructed in avoidance measures for stinging insect, 5) report prepared and sent to primary care physician.

SURVEY DATA:

Specialty: Joint Council of Allergy, Asthma, and Immunology

Sample Size: 55 Response Rate (%): 60.00 Median RVW: 33.00

25th Percentile RVW: 0.20 75th Percentile RVW: 1.53 Low: 0.08 High: 4.24

Median Pre-Service Time: 10 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 17.5 75th Percentile Intra-Svc Time: 73.5 Low: 3 High: 150Median Post-Service Time / Day of Procedure 11.5**KEY REFERENCE SERVICE(S):**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), and/or maximal voluntary ventilation.	0.17
99243	Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and, medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.	1.47
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and , straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient(s) and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.	1.11

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

DESCRIPTION OF THE PHYSICIAN WORK COMPONENTS**A. PRE-SERVICE WORK**

Pre-Service Work Clinical Description: Median Pre-Service Time (min.): 10 min.

For CPT Code 95015 to be undertaken, the patient would already have had an informed consent discussion as part of 95010 which must precede 95015. The risk of anaphylaxis is greater with intra-cutaneous testing. In

this testing, therefore, the patient has a brief reminder of potential reactions. Physician's must access the patient for the development of anaphylaxis from the immediately preceding prick/puncture testing and then determine safe starting doses for testing.

B. INTRA-SERVICE WORK

Intra-Service Work Clinical Description: Median Intra-Service Time (min.) 30 min.

Intra-service work in venom, drug and biologic testing involves determination of whether there was a reaction - skin or anaphylaxis - to the previous test set and whether it is safe to proceed onto the next test.

Comparison to Reference Service(s) Including Intra-Service Work Time and Intensity:

Each of these test sets involves 1-5 tests applied at the same time with approximately 5 groupings of 1-5 tests for venoms, and a variable number, but generally 5 for drugs and biologics. These tests are applied sequentially. The larger number of tests are done for venom testing and we calculate that on average patients have a total of 17 tests divided in 5 sequential groups. The stress of possible anaphylaxis from the previous test set is again substantially greater than for spirometry and is equal to that or greater than that of a Level III Consultation. While there are fewer diagnostic choices and therapeutic choices in skin testing than in an E&M code, the increase stress more than makes up in the differences in intensity in testing and doing a detailed history and physical with low complexity (99243) and much more than makes up for the difference with 99242.

The time involved in 95015 is that of doing 5 different test groups and waiting for 10 minutes to read the tests, as well as, in each instance, determining the presence or absence of anaphylaxis in the safety to proceed to the next sequential test group. The physician must be present for the entire period of time. The total intra-service time for approximately 5 test groups is 17 minutes for each test set. This would involve, therefore, about 85 minutes as compared to 99243 (40 minutes) or 99242 (30 minutes). It is impossible to separate pre- and intra- service test times because these tests are applied in sequential groups of 1-5. One test set application depends upon there being no reaction to the previous test group.

C. POST-SERVICE WORK

Post-Service Work Clinical Description: Median Post-Service Time (min.) 11.5 min.

The post-service time involves explaining to the patient the results of the prick/puncture and intra-cutaneous testing and making recommendations to the patient for environmental controls (venoms), immunotherapy (venoms) and safety of taking or not taking the drug or biologic tested. In addition, the post-service work involves sending a report to the attending physician with recommendations.

Comparison to Reference Service Including Post-Service Work Time and Intensity:

The post-service work is greater than the reference code 94010 because the interpretation of pulmonary function testing is generally less complex than making recommendations about administration of venom immunotherapy or administration of test drugs and possible reactions. There is relatively little difference between this testing and a Level III Consultation, but the time and complexity of testing is greater than that of a Level II Evaluation and Management visit.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Please see above.

CMD Comments

06-Jul-95

Code: 95015

1995 RVUs: 0.15

Recommended RVUs: 0.07

Ratio: -0.53

Long Descriptor: Intracutaneous (intra dermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, specify number of tests

Reference Set (y/n): N Global Period: XXX Frequency: 41,300 Impact: -3304

Source: 8 Year: 93 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
95015			
	93510 LEFT HEART CATHETERIZATION	4.33	000

CMD Comment:

This code allows for the billing of number of tests done per visit. The average number of tests done per visit from our data is 30 tests with an RVUs of 0.15 for each scratch test (done commonly by the nurse). The total RVUs for that service are 4.50. This would relate to a little more than the reference code 36215 and would be 0.17 RVUs greater than the reference code 93510. Neither of these latter procedures are done "incident to" and both require greater intensity and skill. Reducing the RVUs to 0.07 per service, reduces the average total RVUs to 2.10. Which is approximately the mid- point between reference codes 99204 and 99205. Even at that, the service could still be overvalued.

Societies Wishing to Survey: AAO-HNS, JCAI

Societies Wishing to Comment: AAD, ACCP, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
95015	24.1	5.4	2.1	74	20.4	0	1.4	2.1

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
95015	.	39000	.

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
95015	.	3.2	.

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
95015		
	allergy	61.4
	general/family practice	6.8
	group practices	3.7
	internal medicine	8.9
	otolaryngology	11.8

CMD Comments

06-Jul-95

Claims-Level Diagnosis Information:

ICD9	Pct of Time Used	ICD9 Descriptor
95015		
386	1.6	VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM
472	1.7	CHRONIC PHARYNGITIS AND NASOPHARYNGITIS
477	10.6	ALLERGIC RHINITIS
493	1.2	ASTHMA
989	6.4	TOXIC EFFECT OF OTHER SUBSTANCES, CHIEFLY NONMEDICINAL AS TO SOURCE
995	7.2	CERTAIN ADVERSE EFFECTS NOT ELSEWHERE CLASSIFIED

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
95015							
CMD			XXX		0.15		

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
95015								
CMD	0.15	0.15			1.00	1.00	0.07	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
95015								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
95015									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
95015									
CMD				0.07	0.15				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95075 Global Period: XXX Current RVW: 0.95 Recommended RVW: 1.15

CPT Descriptor: Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)

Source and Summary of Comment to HCFA on this service:

CMDs have recommended a decrease in the RVW to 0.60. Our median survey results indicate a value of 1.15. 102 physicians, including both internal medicine allergists and otolaryngic allergists were surveyed. The response rate was about 55 percent. The top reference service chosen (99214) was identical for both groups even with different reference lists.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47 year old male is seen complaining of nasal congestion with sneezing and rhinorrhea. A previous airborne allergy workup was negative. His ear, nose and throat exam is normal except for pale, edematous, wet, and swollen mucosa in the nasal airway. His food diary suggests that foods containing wheat may be a problem. He is given a wheat elimination diet for two weeks, but is non-compliant. His skin test for wheat is equivocal. After re-counseling by the physician and 3 days of strict wheat avoidance, the patient's nasal symptoms have improved. An oral challenge with wheat flour on the 5th day of wheat-containing food avoidance diet is given in the physician's office. The patient experiences a significant return of his nasal symptoms within 30 minutes of the food challenge. Wheat avoidance measures are explained. A return appointment in one month is given.

Description of Pre-Service Work: Physician determines from the patient evaluation that food hypersensitivity may be present. Written instructions regarding the dietary elimination of specific foods are explained and given to the patient in preparation for the food ingestion challenge.

Description of Intra-Service Work: A technician reviews the protocol for patient preparation for the test. The patient's suspected allergy-related signs and symptoms are noted and recorded. If the preparations are met and the physician is present, the technician administers the food. For the next hour the patient, technician and, when appropriate, the physician record signs and symptoms that may occur. If a reaction occurs during the first hour and it is not severe, the test is considered positive and is ended (may perform a similar test with placebo control a week to a month later if there has not been a severe food reaction, or obvious, objective signs of an allergic response, such as profuse rhinorrhea, a decrement in pulmonary functions or the like). If there is no reaction after one hour, 1/2 of the original portion is administered and the same observation occurs for the next hour. If there is no reaction after the second meal, the test is considered negative.

Description of Post-Service Work: Interpretation of test results is documented. If the test is positive, detailed information is given to the patient on avoidance and management of an adverse reaction if it occurs during future exposures, and the patient is given a prescription for epinephrine and instruction in self-administered injections. If the test is negative, consideration is given to other possible offending allergens.

SURVEY DATA (JOINT):

Specialty: American Academy of Otolaryngology - Head and Neck Surgery
Joint Council of Allergy, Asthma, and Immunology
American Academy of Otolaryngic Allergy

Sample Size: 102 Response Rate (%): 54.90 Median RVW: 1.15

25th Percentile RVW: 0.94 75th Percentile RVW: 2.01 Low: 0.17 High: 5.00

Median Pre-Service Time: 15 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 17.5 75th Percentile Intra-Svc Time: 60 Low: 5 High: 240

Median Post-Service Time / Day of Procedure: 15

KEY REFERENCE SERVICE(S):**Allergy and Immunology:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	0.94
94070	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after test dose of bronchodilator (aerosol only) antigen, exercise, cold air, methacholine or other chemical agent, with spirometry as in 94010.	0.60
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	0.55

Otolaryngology - Head and Neck Surgery:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RW</u>
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	0.94
99284	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history, a detailed examination; and, medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	1.68

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Allergy and Immunology:**DESCRIPTION OF THE PHYSICIAN WORK COMPONENTS****A. PRE-SERVICE WORK**

Pre-Service Work Clinical Description: Median Pre-Service Time (min.) 15 min.

(See clinical description above.) This period involves explaining to the patient the nature of the testing and obtaining informed consent by explaining risks and benefits of test procedure.

Comparison to Reference Service(s) Including Pre-Service Work Time and Intensity:

Pre-service work of ingestion challenge is much more intense because of the informed consent discussion than is the pre-service work in 99214 which involves primarily review of former records. There is little if any difference in pre-service work in 95075 and the reference code 94070 since both involve similar procedures. Pre-service work in 99213 is substantially less than 99214 noted above and therefore substantially less than 95075 for reasons already stated.

B. INTRA-SERVICE WORK

Intra-Service Work Clinical Description: Median Intra-Service Time (min.) 30 min.

The patient has a blinded food or placebo administered every 30 minutes in sequentially increasing concentrations. While each test takes about 30 minutes, the whole test period is between 4 and 8 hours. During each test period, the patient is observed for both a decrease in air flow (pulmonary function test) as well as other clinical symptoms and determination made for safety to administer the next test dose.

Comparison to Reference Service(s) Including Intra-Service Work Time and Intensity:

99214 Intra-service time is much shorter than the 4-8 hour period of 95075 and the intensity of potential systemic reactions makes this at least as complex the Level IV established patient. There is no difference in intra-service work with 94070, but the time involved is about double for 95075. CPT Code 95075 also has greater time and intensity than a Level III established patient visit; 99213 which generally is a follow-up visit.

C. POST-SERVICE WORK

Post-Service Work Clinical Description: Median Post-Service Time (min.) 15 min.

Interpretation of test results is documented. If the test is positive, the patient is given detailed information on avoidance and management should an adverse reaction occur on accidental ingestion. Patient is given a prescription for epinephrin and instructed in self administration. If the test is negative, consideration is given to other offending allergens; report is prepared and sent to referring physician.

Comparison to Reference Service Including Post-Service Work Time and Intensity:

There is about the same time and intensity in 95075 as in 94070 and 99214, but substantially greater intensity in ingestion challenge than in a Level III Established Patient Visit (99213)

Otolaryngology - Head and Neck Surgery:

See Allergy and Immunology reference service comparisons discussed above. In addition, the reference services chosen by otolaryngologists in the survey include #99214 and #99284. Taking #99214 and #95075, an "established patient" is involved, which means that most pre-service work has been accomplished at a prior (separately billed) visit. This is in contrast to the #99284 situation where the physician must take a phone call from an emergency room, travel to an emergency department rather than the routine office setting and review the emergency room record prior to seeing the patient. The intra-service work and physician time for #95075 is substantially greater than for #99214, as though both involve further detailed medical history and some physical examination the #95075 service entails at least a one hour period of observation after the aforementioned, and possibly two hours during which time the physician is involved depending on the patient's symptoms and technician/nurse needs (not less than an additional 15-30 minutes of patient contact).

In intra-service work #95075 would involve similar or more time than would #99284. The psychological stress and mental effort might be similar in #95075 and #99284, more for #95075 should the patient develop a systemic allergic response. For post-service time, #95075 requires substantially more physician time than #99214, and the same or more time than #99284 as a food elimination diet must be explained to the patient, and instruction in self-administration of epinephrine may be needed. The intensity of physician effort for #95075 is somewhere between #99214 and #99284, as patient observation in allergy food test can range from prolonged but mundane observation to a serious allergic reaction requiring emergent intervention.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Please see above.

Also, there has been no substantial change in the ingestion challenge food test over the past 5 years. Attached are 3 reprints, 2 written by general allergists, and another by an otolaryngic allergist. As per the #95075 vignette, the main component of physician involvement is intra-service work, consisting of a brief physical examination and a history review to confirm that the patient has eliminated specific foods from the diet prior to the test. The physician will be involved in periodic patient evaluation during the 1 to 2 subsequent hours of challenge ingestion food testing, and will need to evaluate potential allergic responses, life threatening in rare instances, and thereafter to counsel the patient regarding dietary elimination (and, possible epinephrine usage if food sensitivity has been confirmed by the ingestion test. Physician physical effort is minimal unless there is a (rare) severe allergic reaction; mental effort and judgement are moderate; time period is substantial (1.5-2.5 hours albeit not in constant patient contact); stress is related to the severity of any allergy reaction.

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Great care has been taken to maintain the accuracy of the information contained in the volume. However, neither Carnation nor Raven Press can be held responsible for errors or for any consequences arising from the use of the information contained herein.

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Preface

In my "Bela Schick Memorial Lecture" to the American College of Allergists (on the subject of food allergy, I presented some of the results of our studies on the consequences of feeding cow's milk formulas instead of human breast milk to human babies and the problems created by the too-early introduction of solid foods, especially to infants from allergic families. One of the titles of the talk was "Food Allergy in Children and Adults: Overt to Covert," since we, pediatricians, see twice as much disease owing to allergy as do the internists and perhaps ten times more food allergy than they do. As a result, there is a tendency for internists and family physicians to overlook the not so rare adult with symptoms caused by the ingestion of a food.

This book is modeled after a European effort on a related topic, which is an invaluable reference work (2). We have addressed five topics within the text of *Food Intolerance in Infancy: Allergology, Immunology, and Gastroenterology*. In order to better understand the clinical aspects, we examined the biology and physiology of both the digestive and immune systems; we explored the various types of food intolerance we discussed the diagnosis, prevention, amelioration, and treatment of milk intolerance; and we introduced to the United States a new hypoallergenic infant formula.

You will note that each section of this book is introduced, not necessarily by a worker in the field, but by an experienced and critical academic physician, each of whom briefly introduces the subject of the section. Each was responsible for seeing to it that none of the authors told you "more than you ever wanted to know about 'X'." I have rigorously edited the discussions which follow each section and therefore take full responsibility for any errors of omission or commission.

The Carnation Company provided me with the opportunity to organize a symposium and to assemble world-class authorities on food intolerance, including food allergy, many of whom are friends. Thus, we had the added pleasure of working with friends in the presentation of our studies and the discussion of our ideas. My hope is that you enjoy the book based upon the Food Allergy Symposium held in New York City, September 29 and 30, 1988, as much as we did preparing it.

This book will be of interest to all those who care for infants and children, especially pediatricians, family physicians, general practitioners, allergists, nutritionists, and nurses, as well as gastroenterologists and immunologists.

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ROBERT N. HAMBURGER

rare in and even the acquired variety causing clinically significant
nge is und
Our task at this meeting is to illuminate as much as possible what is known about
immunologic problems associated with infant feeding. We need just to see if there
solutions to the problems already at hand; perhaps most important, we need to
see those problems for which we now have the scientific basis for resolution.
Having identified myself as a skeptic, I now propose to introduce a session on the
techniques for diagnosing food allergy, keeping an open mind as we all evaluate the
evidence.

In Vivo Diagnosis of Food Allergy

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The diagnosis of food allergy is predominantly clinical. Information on the offending food(s) may be obtained from the medical history, a food/symptom diary, trials of elimination diets, and skin testing. To verify the role of suspected foods, each should be subjected to well-controlled oral challenge testing.

Skin testing is probably the most commonly utilized diagnostic procedure in food allergy. Its reliability, however, is generally suboptimal and varies from one food to another. It has an overall positive predictive accuracy of 48% and a negative predictive accuracy of 74%.

Elimination-challenge testing is the most definitive procedure for verification of the role of suspected foods. Placebo-controlled blind challenges are ideal, yet have limitations; disguising an adequate quantity of food or choosing an appropriate placebo may be difficult. The challenge method also may be very different from the method of natural exposure. The test should be done under medical supervision to document the occurrence of reaction and to treat any potentially severe ones.

In evaluating patients suspected of having food allergy, information on the offending food may be pursued in several ways (1). Medical history, food/symptom diary, trials of elimination diets, and skin testing are widely used (Table 1). Certain *in vitro* tests may also be used and are addressed in *this volume*. To verify the role of a certain food in inducing a particular symptom, appropriate challenge tests should be conducted.

The underlying hypersensitivity mechanism, however, may be difficult to document, although it may be guessed by the nature of symptoms and time of onset following exposure to food. A positive immediate-type skin test or an increased serum level of specific immunoglobulin E (IgE) antibodies supports an IgE-mediated reaction. More than one immunologic mechanism, however, may be involved in the same patient, particularly when there are multiple manifestations (2).

MEDICAL HISTORY

A thorough history may provide valuable information to support or exclude food allergy. Occasionally the medical history may be so obvious as to settle the diagno-

TABLE 1. In vivo diagnostic procedures of food allergy

1. Medical history
 - a. Relation of symptoms to food intake
 - b. Specific foods suspected
 - c. Association with other factors
2. Food/symptom diary
 - a. Regular daily recording
 - b. Recording whenever symptoms appear
3. Trials of elimination diets
 - a. Conventional elimination diets (e.g., Rowe's)
 - b. Individualized diets devoid of certain foods
 - c. Elemental diet
 - d. Hypoallergenic formula for infants
4. Skin testing
 - a. Epicutaneous (scratch; puncture; prick)
 - b. Intracutaneous
5. Challenge testing
 - a. Oral
 - b. Inhalation

sis without the need for further tests. This would be the case in patients whose symptoms are objective and well defined (e.g., urticaria, angioedema, or wheezing), have occurred intermittently, and on multiple occasions have appeared shortly after exposure to a particular food. The history may reveal the involvement of other factors in addition to food (e.g., physical exercise, emotional events, or premenstrual time).

FOOD/SYMP TOM DIARY

A regular tabular recording by date and time of all foods eaten and the appearance or exacerbation of symptoms may assist in suspecting the offending foods. The food/symptom diary is most effective when the symptoms are well defined, occur intermittently, last for a short time, and appear shortly after exposure to a food that is not eaten on a daily basis. The recording should encompass a few recurrences of symptoms.

The diary is of little help if the recording is incomplete, if the offending food is incorporated in frequently eaten dishes, or in cases of delayed-onset reactions. The patient may not be aware of a "hidden" food allergen in a commercially prepared food, either because it is not listed on the label or is listed under a name unfamiliar to the public (e.g., whey, casein, calcium caseinate, ovalbumin, ovomucoid, or ovomucin).

In addition to foods, other events may need to be recorded, such as places visited, social activities, emotional events, menses, and physical exercise. Any such factors may contribute to the patient's symptoms or potentiate the effect of food allergens.

In these cases, recording may be done only whenever symptoms occur and should include a sequential recording of foods eaten and events happening during the preceding 12 to 24 hr.

DIAGNOSTIC ELIMINATION DIETS

Certain elimination diets may be tried in patients whose symptoms are frequent or persistent and whose medical history suggests food allergy without pointing to any particular food. Some conventional diets are devised to be devoid of certain group(s) of commonly allergenic foods. Rowe Elimination Diets Number 1, 2, 3, and 4 are widely known examples (3,4). Elemental formula (Tolerex or Standard Vivonex by Norwich Eaton Pharmaceuticals, or Vivasorb by Phrimer A/S) is a strict elimination diet. The protein in this formula consists of synthesized amino acids (5,6). These elimination diets have some advantages and several disadvantages (7). In infants, a hypoallergenic formula may be given, e.g., casein hydrolysate (Nutramigen by Mead Johnson Nutritional Division) or the recently available whey hydrolysate (Good Start H.A. by Carnation).

Selection of the initial elimination diet may vary from one patient to another. If no improvement in symptoms is noted within 2 to 4 weeks, other elimination diets may be tried. Once improvement occurs, the eliminated foods are reintroduced one at a time to identify the offending ones.

SKIN TESTING

In evaluating patients for food allergy, physicians have shown divergent attitudes towards the usefulness of skin testing. At one extreme are those who do not use food extracts for skin testing, and at the other extreme are those who diagnose food allergy by skin testing alone. At present, skin testing is probably the most commonly used procedure in evaluation of food allergy. Reports on its reliability, however, have shown inconsistent results (8-12).

The allergen extract is usually applied epicutaneously (i.e., by scratch, prick, or puncture techniques). Commercial food extracts for epicutaneous testing are mostly provided in a concentration of 1:20 or 1:10 w/vol (50% glycerinated). Fresh food, however, may be superior to the commercial extracts (13-15). If the test is negative to the foods suspected from the history, intracutaneous testing may be performed by injecting 0.02 ml of aqueous extract, usually 1:1,000 w/vol. Performing epicutaneous testing first minimizes the risk of systemic or large local reactions that might result from intradermal administration of an allergen to which the patient is highly sensitive.

The test sites are inspected after 15 to 20 min for the size of the wheal-and-flare response, which reflects an IgE-mediated reaction. A score from 0 to 4+ is given as compared with the response to a diluent and to histamine (2). Most allergists con-

challenge

We studied allergy patients, mostly children, whose histories were highly suggestive of food allergy (16). They were subjected to scratch testing with commercial food extracts; whenever the reaction score was 1+ or 0 and the food was suspected from the history, intradermal testing was done. Double-blind, placebo-controlled oral challenges were performed with the food that showed a positive skin test (2+ or greater) or were suspected from the history. The results of skin testing and challenge were concordant in 63% of all instances (Table 2). In the positive challenge group, skin testing was positive in 58% of instances, but varied from one food to another, being lowest for tomato (33%) and highest for fish (83%). In the negative challenge group, skin testing was negative in 65% of instances, lowest for fish (50%) and highest for orange (89%). The overall positive predictive accuracy of skin testing was 48%, lowest for crab (33%) and highest for fish (83%). The overall negative predictive accuracy was 74%, lowest for cow's milk (44%) and highest for egg white (89%). The presenting symptoms in our series were asthma and/or rhinitis in 76%, atopic dermatitis in 47%, urticaria/angioedema in 47%, gastrointestinal symptoms in 27%, and systemic anaphylaxis in 12%. Nevertheless, the results previously reported on atopic dermatitis patients were not much different (17).

A discordance between the results of skin testing and challenge testing might be caused by any of several factors, such as technical errors, non-IgE-mediated reactions, the specific reagents being more localized in the shock organ, or the presence of subclinical hypersensitivity (2).

The suboptimal reliability of skin testing with the currently available food extracts should not deter its use as a screening test, particularly since none of the currently available *in vitro* tests has optimal reliability (1). In a series of 102 adults who had a history of idiopathic anaphylaxis, skin testing with food extracts assisted in identifying the cause in 7 subjects (18).

A high concordance rate between positive skin-test reaction and challenge testing has been noted in studies that used purified allergen extracts, such as codfish (9) and peanut (19). Purification and standardization of food allergy extracts are complex processes, but may be forthcoming (20).

TABLE 2. Concordance between the results of skin testing and double-blind oral food challenge

Group	N	Concordance, %		
		Overall	Lowest	Highest
All challenges	107	62.6	53.3 (milk)	75.0 (fish)
Positive challenge group	38	57.9	33.3 (tomato)	83.3 (fish)
Negative challenge group	69	65.2	50.0 (fish)	88.9 (orange)

ELIMINATION CHALLENGE TEST

To verify the role of foods suspected (by history, diary, trials of elimination diet, skin testing, or *in vitro* tests), the patient should first avoid all these foods, and then be subjected to oral challenge with each separately. (The challenge must be avoided, however, if the food being considered may have been the cause of a life-threatening reaction in the past.)

The first phase of the test aims at documenting definite improvement in symptoms following a trial of dietary elimination. All suspected foods should be simultaneously and completely avoided for 1 to 2 weeks. If the symptoms do not improve substantially, either that food is not the offender or additional offending factors were not controlled. If the symptoms definitely improve, the patient should be subjected to oral challenge tests while taking no or minimal symptomatic medications and having no intercurrent illness.

The second phase of the test aims at documenting recurrence of symptoms following exposure to the offending food. Generally, the challenge test should be done under supervision and in a place where facilities exist for the management of any possible severe reaction. We, as well as others (21,22), have witnessed severe reactions, including systemic anaphylaxis, from oral challenge tests in some patients who had had no such reactions before.

The initial challenge dose of food should depend on the anticipated severity of symptoms and on the quantities of the food the patient had been accustomed to eating while symptomatic. Increasing quantities may be administered every 30 min, as long as no reaction appears, until a cumulative quantity is reached that is equivalent to what the patient usually used to eat. On another visit, a challenge with an appropriate placebo should be carried out in the same way as with the suspected food. In addition to documenting all clinical symptoms and signs, the physician should record, whenever applicable, any changes in relevant laboratory findings. In a clinic setting, if no reaction occurs during the challenge procedure (usually 3 to 4 hr), the patient is sent home with instructions to maintain the elimination diet and to report any symptoms. If no symptoms occur by the next day, more of that food may be eaten at home unless the physician prefers not to disclose the nature of the challenge tests until all the challenges are completed.

In infants and young children, where reactions are mostly objective, the challenge may be conducted in an open manner. In older children and adults, however, the test should be conducted in a blind manner, usually single-blind and occasionally double-blind. Difficulties may be encountered in providing a placebo that matches the suspected food in consistency, color, odor, taste, and quantity. Because of this problem, the physician may choose to use open challenge testing first, then verify by a blind test only those foods that cause a reaction. This approach would save much time because a negative result occurs in approximately two-thirds of blind challenge tests (11,12,23,24). A common method of hiding the test food is providing it in a freeze-dried powder in opaque capsules. It can be also disguised in a hypoallergenic formula, an elemental formula, or in another appropriately selected food.

Results of 107 double-blind oral challenges in patients highly suspected to be food allergic, a clinical reaction was noted in 36% (12). The reproduced symptoms were mostly similar to the presenting symptoms. In a few instances, additional symptoms were noted, including systemic anaphylaxis in one. With few exceptions, all positive reactions appeared while the patient was being observed in the clinic. In a few instances the reaction occurred at home within 24 hr after challenge.

Although oral challenge is the most definitive test for identification of the offending food, it has some limitations. It relies on the appearance of clinical symptoms and might miss a subclinical reaction (25,26). It is conducted under controlled conditions that might be different from the usual circumstances of exposure in certain patients, such as food preparation, combination with other foods, association with other contributory factors, or route of exposure. Certain food hypersensitivity reactions, mostly respiratory, are precipitated by inhalation rather than ingestion (1,2). Verification of these reactions requires specially designed bronchial inhalation challenge tests (27).

ACKNOWLEDGMENT

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Otolaryngologic Allergy

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1981

The Oral Challenge Food Test

William H. Wilson, M.D.

Objective

This paper briefly presents the technique for performing the oral challenge food test.

The oral challenge test for determining hypersensitivity to a specific food dates back to the original employment of the concept by Duke [1] in 1923. The reintroduction of a food that had been eliminated from the patient's diet because of a suspected labyrinthine excitation resulted in an episode of acute vertigo.

Rinkel [2] reported the use of a deliberate feeding test in 1934 in diagnosing a gastrointestinal allergy that mimicked a peptic ulcer syndrome. His technique involved total elimination of the suspected food for four full days, with reintroduction on the fifth day. His technique was further refined by Randolph in 1946 by correlation of the clinical response of the test with the changes occasionally noted in the white blood count. This he referred to as the leukopenic index.

Rinkel [3] defined food allergy as "a hypersensitivity to or an intolerance of a food which is demonstrable by the production of clinical manifestations with specific means of testing." The oral challenge food test meets this criterion.

An understanding of the principle of the test awaited recognition of the phenomenon of masking as described by Rinkel, and later referred to by Randolph as the phenomenon of adaptation. Understanding of the cyclic aspect of hypersensitivity to foods brought a realization that it was the elimination of the phenomenon of adaptation during the four

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days of abstinence that made possible the clinical response upon reintroduction if a specific hypersensitivity existed. This induced phase of acute hypersensitivity actually returns the patient to a state of nonadaptation.

The challenge test may be performed in the physician's office or in the patient's home. Professional observation is most desirable, but a well-instructed patient or parent of moderate intelligence should be able to record clinical signs and symptoms observed upon reintroduction of the food undergoing a test. The physician's office affords a controlled environment, but the home is suitable and can be made acceptable with proper instruction. Warning that exposure to possible inhalant allergens during the test day may produce a false-positive response is essential.

Blood pressure determinations in the hypertensive patient and white blood counts before and after the feeding test are available only in an office setting, but rarely are essential in determining a positive test response.

The greatest source of error in the oral challenge test lies in the possibility that the food being tested inadvertently entered the diet during the four days of elimination. Performing the challenge in the office fails to offer any additional safeguard from this standpoint. The convenience and economy of utilizing the home as the test site not only adds practicality but also materially lessens traffic in a busy medical office.

Verbal detailing of which foods can and cannot be ingested during the four days of total elimination should be supplemented by complete lists tailored to the market in the physician's community. The exact procedure to follow on the day of the test must be written and explained in detail.

The patient is instructed to have an early breakfast on the fifth day, the day the food is reintroduced. The food under consideration is not included in the breakfast and no new food is introduced at that meal. Smoking is prohibited and nothing more is taken by mouth until the test meal 3½ hours later. The status of the patient's allergy is evaluated prior to the late-morning feeding. Should the patient be ill or experiencing an exacerbation that day, the test may be postponed until the 6th, 7th or 8th day.

Only the food undergoing the test is ingested at the test meal. The inclusion of other foods slows absorption and may

result in an equivocal response. An average portion is eaten within a five-minute period. The environment should remain stable. Significant signs and symptoms are noted and recorded. If they are definite, further ingestion of the food is contraindicated.

One hour after the initial ingestion of the test food the patient eats one-half portion more. No other food enters the diet for one hour, and all observations are recorded. The noon meal may follow. All symptoms and signs that occur during the afternoon and evening require recording, and notations are made the next morning as to any occurrences during the night.

The oral challenge test offers an approximate 80% accuracy. If a hypersensitivity to a specific food remains suspect following a negative challenge, the intracutaneous provocative test offers an alternative technique. The oral challenge test also offers an alternative methodology when a highly suspected food fails to produce a positive response by the intracutaneous provocative method.

An adjunctive value of the test lies in the self-instruction it affords the physician as to the nature of allergy to foods as he observes the reported responses of his patients during their specific challenges.

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Self-Evaluation Quiz

1. The underlying principle of the oral challenge food test has been described as:
 - a) Elimination of the phenomenon of masking
 - b) Elimination of the phenomenon of adaptation
 - c) Return to nonadaptation
 - d) All of the above
2. Four days of abstinence from an allergenic food induces acute hypersensitivity in an affected individual.

CMD Comments

06-Jul-95

Code: 95075

1995 RVUs: 0.95

Recommended RVUs: 0.60

Ratio: -0.37

Long Descriptor: Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)

Reference Set (y/n): N **Global Period:** XXX **Frequency:** 1,289 **Impact:** -451.15

Source: 7 **Year:** 93 **Public Comment Letter:**

Reference Services:

	Short Descriptor	RVU	Global
95075			
	94070 EVALUATION OF WHEEZING	0.60	XXX

CMD Comment:

CPT 95075 is most commonly done to determine the effect on the airway. It is done by having the patient ingest a particular substance (e.g., metabisulfite) and doing repetitive spirometry or flow volume loops. This is essentially the same as 94070.

Societies Wishing to Survey: AAO-HNS, JCAI

Societies Wishing to Comment: AAD, ASIM

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
95075	50	0	0	75	0	0	0	0

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
95075	889	1556	32.3

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
95075	0.4	1	0.3

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
95075		
	allergy	41.3
	general/family practice	17.2
	internal medicine	7.5
	otolaryngology	32.9

Claims-Level Diagnosis Information:

CMD Comments

06-Jul-95

ICD9	Pct of Time Used	ICD9 Descriptor
95075		
477	11.5	ALLERGIC RHINITIS
493	3.1	ASTHMA
729	5.2	OTHER DISORDERS OF SOFT TISSUES
786	2.1	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS
995	3.1	CERTAIN ADVERSE EFFECTS NOT ELSEWHERE CLASSIFIED
E930	1	ANTIBIOTICS CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
95075							
CMD			XXX		0.95		0.00

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
95075								
CMD	0.95	0.95			1.00	1.00	0.60	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
95075								
CMD	XXX							

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
95075									
CMD									

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
95075									
CMD				0.60	0.95				

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95937 Global Period: XXX Current RVW: 0.60 Recommended RVW: 0.65

CPT Descriptor: Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method

Source and Summary of Comment to HCFA on this service:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 25-year-old woman has noted intermittent ptosis of the eyelids and double vision for 3 months. Physical examination is normal except she develops ptosis of the eyelids after 60 seconds of sustained upgaze. A primary diagnostic consideration is myasthenia gravis. Acetylcholine receptor antibody titers and a Tensilon test are normal. Repetitive nerve stimulation studies of a hand and shoulder muscle are normal. Repetitive nerve stimulation studies of the inferior orbicularis oculi and nasalis muscles innervated by the facial nerve are abnormal, showing a decrement-increment pattern on 2 Hz and 3 Hz stimulation. The abnormal facial repetitive nerve stimulation studies demonstrate abnormal neuromuscular transmission and support the clinical diagnosis of myasthenia gravis.

Description of Pre-Service Work:

Pre-service work involves the examiner determining which nerve-muscle pairs are to be studied based on the referring physician's questions and the available clinical information.

Description of Intra-Service Work:

Intra-service work includes physician performance or supervision of patient preparation, setting the electromyograph's gain setting, time base and filter settings, placement of ground, stimulating and recording surface electrodes, stimulation of nerves and recording of the waveforms of the resulting compound muscle action potentials. If possible, the body part receiving the stimulation is immobilized to minimize motion artifacts that often interfere with reliable data collection. This is much more easily done if a distal limb nerve is stimulated. The compound muscle action potential waveforms are analyzed with respect to amplitude and configuration and, sometimes, area following one or more trains of repetitive nerve stimulation. Different numbers and rates of stimuli are delivered depending on the clinical situation. Test design changes during the course of the study in response to the information obtained.

Description of Post-Service Work:

Post-service work involves calculation of compound muscle action potential amplitude and configuration change during the course of the trains of repetitive nerve stimulation, sometimes calculation of compound muscle action potential area change during the course of the trains of repetitive nerve stimulation, comparison to normal values, summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and sometimes suggestions for further work-up.

SURVEY DATA:

Specialty: American Association of Electrodiagnostic Medicine

Sample Size: 58 Response Rate (%): 72.4% Median RVW: 0.65

25th Percentile RVW: 0.60 75th Percentile RVW: 0.70 Low: 0.55 High: 2.00

Median Pre-Service Time: 5 minutes Median Intra-Service Time: 12 minutes

25th Percentile Intra-Svc Time: 8 min 75th Percentile Intra-Svc Time: 20 min Low: 0 min High: 40 min

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 5 min

ICU: 0 0

Other Hospital: 0 0

Office: 0 0

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	95900	Nerve conduction, velocity and/or latency study; motor, each nerve	0.42
2)	95935	"H" or "F" reflex study, by electrodiagnostic testing	0.59
3)	95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing	0.59

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The following table compares the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the surveyed CPT code 95937 to the key reference services used in the survey.

<u>Reference Service</u>	<u>RVW</u>	<u>MEDIANS</u>			<u>AVERAGES</u>		
		<u>Pre Time</u>	<u>Intra Time</u>	<u>Post Time</u>	<u>Mental Effort/ Judgment</u>	<u>Technical Skill/ Physical Effort</u>	<u>Psychological Stress</u>
95900	0.42	5.0	5.0	2.0	2.1	2.2	1.9
95935	0.59	5.0	10.0	4.0	2.7	3.0	2.6
95933	0.59	4.0	9.0	4.0	3.0	2.9	2.4
<u>Survey Code</u>	<u>Proposed RVW</u>						
95937	0.65	5.0	12.0	5.0	3.4	3.7	2.9

As can be seen in the above table, pre-service time for code 95937 was equal to or greater than pre-service time for the reference services. Intra-service and post-service times were greater for code 95937 than the three reference services. The degree of mental effort and judgement; technical skill & physical effort; and psychological stress associated with code 95937 was greater than that of any of the reference services. The ratio of the proposed RVW for code 95937 (0.65) to that of reference services 95935 and 95933 (0.59) is 1.10. The ratio of intra-service time for code 95937 (12 min) to that of the average intra-service time for reference services 95935 and 95933 ($\{(9 + 10) / 2\} = 9.5$) is even greater, at 1.26.

Comparison of the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the surveyed CPT code 95937 to the key reference services supports the recommendation that the RVW for 95937 should be higher than the RVWs for any of the reference services.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

Pre-Service Work (5 minutes):

Pre-service work involves the examiner determining which nerve-muscle pairs are to be studied based on the referring physician's questions and the available clinical information. Level of technical skill & physical effort; mental effort and judgement; and stress is that required to perform a medical history and physical examination and to understand the role of code 95937 in the diagnostic process of neuromuscular diseases.

Intra-Service Work (12 minutes):

Intra-service work includes physician performance or supervision of patient preparation, setting the electromyograph's gain setting, time base and filter settings, placement of ground, stimulating and recording surface electrodes, stimulation of nerves and recording of the waveforms of the resulting compound muscle action potentials. If possible, the body part receiving the stimulation is immobilized to minimize motion artifacts that often interfere with reliable data collection. This is much more easily done if a distal limb nerve is stimulated. The compound muscle action potential waveforms are analyzed with respect to amplitude and configuration and, sometimes, area following one or more trains of repetitive nerve stimulation. Different numbers and rates of stimuli are delivered depending on the clinical situation. Test design changes during the course of the study in response to the information obtained. Level of technical skill & physical effort; mental effort and judgement; and stress is that required to perform electrodiagnostic testing,, as described above, and to interpret the results obtained during the course of the study within the clinical context, so that further studies, if necessary, can be done in order to maximize the chance of arriving at a proper diagnosis while minimizing patient inconvenience and discomfort.

Description of Post-Service Work (5 minutes):

Post-service work involves calculation of compound muscle action potential amplitude and configuration change during the course of the trains of repetitive nerve stimulation, sometimes calculation of compound muscle action potential area change during the course of the trains of repetitive nerve stimulation, comparison to normal values, summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and sometimes suggestions for further work-up. Level of technical skill & physical effort; mental effort and judgement; and stress is that required to correctly analyze and interpret the results of the electrodiagnostic testing, and to place them in a clinical context so that the report is meaningful to the referring physician in terms of a reasonable differential diagnosis and sometimes suggestions for treatment or further evaluation.

Change in the Work of Performing the Service Over the Past Five Years:

The work of performing the service has changed little over the past five years. Only 1 of the survey respondents stated that the site of service has changed from in-patient to out-patient. Only 1 of the survey respondents stated that this service represents new technology that has become more familiar (less work). Only 2 of the survey respondents stated patients requiring this service are more complex (more work).

Objective Data Supporting the Rationale:

On June 8, 1995 the AMA sent the AAEM three relevant documents:

1. *Medicare Part B Data for Reference Codes and Codes under Review*
2. *Summary of Work and Time Estimates for Services Undergoing Investigation for the Five-Year-Review*
3. *Comparison of Work RVUs – 1995 MFS versus the Harvard RBRVS Study for Services Undergoing Investigation for the Five-Year-Review*

Each of these documents, in its own way, supports assigning an RVW for code 95937 that is higher than the current value.

Medicare Part B Data for Reference Codes and Codes under Review shows that the frequency of performance of code 95937 has increased from 13,698 in 1992 to 65,134 in 1994, an increase of 118.1%. During the same period, the frequency of performance of reference service 95900 increased only 9.5% and the frequency of performance of reference service 95935 increased only 36%. Information on reference service 95933 is not available.

The proportion of the specialty mix of those physicians reporting reference code 95900 who would be expected to have specialized training in electrodiagnostic studies (neurologists and physiatrists) was 69.6% in 1994. The proportion of the specialty mix of those physicians reporting reference code 95935 who would be expected to have specialized training in electrodiagnostic studies (neurologists and physiatrists) was 50.0% in 1994. However, the proportion of the specialty mix of those physicians reporting reference code 95937 who would be expected to have specialized training in electrodiagnostic studies (neurologists and physiatrists) was only 26.1% in 1994. The AAEM would expect that the patient populations in which the reference services and survey code 95937 would be performed would be similar and that the clinical skills involved in performing the reference services and survey code 95937 would be similar.

Although the AAEM would expect that the usual indications for code 95937 would be the symptom of muscle weakness (ICD-9 code 728.9) or neuromuscular junction disorders (botulism: 005.1, tetanus: 037, myasthenia gravis: 358.0, myasthenic syndromes: 358.1), the ICD-9 codes actually reported with performance of CPT code 95937 are listed below in order of frequency (highest to lowest):

- 355 Mononeuritis lower limb
- 356 Hereditary and idiopathic peripheral neuropathy
- 786 Symptoms involving respiratory system and other chest symptoms
- 724 Other and unspecified disorder of the back
- 729 Other disorders of soft tissues
- 354 Mononeuritis of upper limb and mononeuritis multiplex
- 723 Other disorders of cervical region
- 780 General symptoms

It is difficult for the AAEM to understand the justification for performing neuromuscular junction testing (code 95937) in large numbers of patients with the above diagnoses, although this procedure could be indicated in certain patients with these illnesses and symptoms.

The above Medicare data suggests that the increased utilization of code 95937 from 1992 to 1994 may not be justifiable on clinical grounds. Furthermore, the data suggests that a different population of practitioners are reporting code 95937 than those reporting some other similar electrodiagnostic codes. Perhaps many of the practitioners reporting code 95937 do not understand the true definition of this code.

The AAEM is of the opinion that the optimal remedy for overutilization of a given electrodiagnostic code is peer review of questionable cases and/or development of and adherence to practice parameters regarding electrodiagnostic testing. A decrease in the RVW of code 95937 is not justifiable on the basis of our survey results and the above supporting data and such a decrease would unfairly penalize those practitioners who perform this procedure under the correct clinical circumstances.

Summary of Work and Time Estimates for Services Undergoing Investigation for the Five-Year-Review lists an intratest time for code 95937 at 29 minutes. The intratest time for code 95867, which is also under review (and therefore was not used as a reference service in the survey for code 95937), is listed as 23 minutes, yet the Carrier Medical Directors' recommended RVW for code 95867 is 0.79!

Comparison of Work RVUs – 1995 MFS versus the Harvard RBRVS Study for Services Undergoing Investigation for the Five-Year-Review states that the recommended RVW for code 95937 from the original Harvard RBRVS study was 0.77.

CMD Comments

06-Jul-95

Code: 95937

1995 RVUs: 0.6

Recommended RVUs: 0.51

Ratio: -0.15

Long Descriptor: Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method

Reference Set (y/n): N Global Period: XXX Frequency: 61,376 Impact: -5523.84

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
95937			
	99213 OFFICE/OUTPATIENT VISIT, EST	0.55	XXX

CMD Comment:

The work, expertise, and intensity of 95933 does not equal 99213.

Societies Wishing to Survey: AAEM, AAN

Societies Wishing to Comment: AAPMR

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
95937	34.8	5.1	34	58.9	23.9	1.2	0.9	2.2

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
95937	13698	65134	118.1

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
95937	19.2	6.4	-6.4

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
95937		
	anesthesiology	5.5
	cardiovascular disease	7.1
	general/family practice	22.7
	internal medicine	17.6
	neurology	26.1
	orthopedic surgery	2.4
	other nonphysician prov	3.1
	radiology	9.7

CMD Comments

06-Jul-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
95937	354	3	MONONEURITIS OF UPPER LIMB AND MONONEURITIS MULTIPLEX
	355	8.5	MONONEURITIS OF LOWER LIMB AND UNSPECIFIED SITE
	356	6.8	HEREDITARY AND IDIOPATHIC PERIPHERAL NEUROPATHY
	723	2.6	OTHER DISORDERS OF CERVICAL REGION
	724	4.9	OTHER AND UNSPECIFIED DISORDERS OF BACK
	729	4.6	OTHER DISORDERS OF SOFT TISSUES
	780	2.4	GENERAL SYMPTOMS
	786	6	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS

Harvard Data:

	Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
95937	CMD		XXX	XXX	0.77	0.60	0.78	0.60

Harvard Data:

	Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
95937	CMD	0.60	0.60	0.78	1.00	1.00	1.00	0.51	

Harvard Data:

	Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	itime	Notett	Imppt
95937	CMD	XXX	0.77	t	.	.	29	t	.

Harvard Data:

	Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icvis	Offvis
95937	CMD	.	.	.	.	.	.	.	.	.

Harvard Data:

	Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
95937										

CMD Comments

06-Jul-95

CMD	0.51	0.60	nr	3	0.027
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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 95951 Global Period: XXX Current RVW: 3.8 Recommended RVW: 6.0

CPT Descriptor: Monitoring for identification and lateralization of cerebral seizure focus, combined electroencephalographic (EEG) and video recording and interpretation, each 24 hours

Source and Summary of Comment to HCFA on this service: The American Academy of Neurology (AAN) was the source of public comment to HCFA regarding the refinement of physician work RVU's associated with CPT 95951. It was the opinion of the AAN that the initial Harvard Study value (1.79 RVUs) was gross underestimation of the actual time and intensity of the physician work involved and the current RVU in the MFS (3.8) still represents a highly undervalued value. The complexity of the patients and work associated with this service has increased significantly.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 year-old woman has a 15 year history of partial and grand mal seizures which are still poorly controlled despite all medication regimens tried. Her seizures, occurring 2-3 times per week, have made her unable to work. The MRI and exam are normal. She is referred for long-term video-EEG monitoring. Patient is monitored for four days, during which time eight partial complex seizures were recorded. After cortical resection at the seizure focus, identified by the video-EEG monitoring, the patient is seizure free and eventually stops all medication and returns to work.

Description of Pre-Service Work: Explaining to patient the risks of withdrawing medication, grand mal status, restrictions on behavior, the procedure itself, outcomes, and why it has been recommended for the patient. Instruct technicians as to specific monitoring techniques that should be used for the patient.

Description of Intra-Service Work: For each seizure during a 24 hour period (typically several), a review of the nursing notes and review and interpretation of both the video and EEG recordings from before, during and after seizure. For each 24 hour period a note is written of the behavioral and EEG findings for seizures that day.

Description of Post-Service Work: For each admission (typically several days to a week), dictation of a summary of the video behavior and EEG information recorded with the seizures. Analysis, including comparing and contrasting, the separate types of seizures which were found. Determination of the patient's suitability for surgery, which part of the brain to resect and what risks are involved. Review findings with surgeon and discussion of test results with referring physician, patient, and/or family.

SURVEY DATA:

Specialty: American Academy of Neurology

Sample Size: 60 Response Rate (%): 75 Median RVW: 6.0

25th Percentile RVW: 5.0 75th Percentile RVW: 7.2 Low: 3.0 High: 12.0

Median Pre-Service Time: 30 min Median Intra-Service Time: 60 min

25th % Intra-Svc Time: 60 min 75th % Intra-Svc Time: 90 min Low: 30 min High: 120 min

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 60 min

ICU: N/A N/A

Other Hospital: N/A N/A

Office: N/A N/A

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	95819	Electroencephalogram (EEG) including recording awake and asleep, with hyperventilation and/or phonic stimulation	1.08
2)	99244	Office consultation for a new or established patient, which requires a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.	2.23

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

<u>Time Comparison (Medians)</u>	<u>Reference Services</u>		
	<u>95951</u>	<u>95819</u>	<u>99244</u>
Pre-Service	30	5	10
Intra-Service	60	15	60
Post-Service	60	5	10
<u>Intensity Comparison (Medians)</u>			
Mental Effort & Judgement	5	2	4
Technical Skill & Physical Effort	5	2	3
Psychological Stress	4	2	3

It is obvious from the above comparison of pre, intra, and post service times and complexity/intensity of physician work that CPT 95951 was rated much greater in all aspects than the two primary reference services. The total time associated with CPT 95951 (150 min.) is six times that of the time associated with CPT 95819 (25 min.) and close to twice the time for CPT 99244 (80 min.). The ratio of median intensity factors for CPT 95951 compared to CPT 95819 is 2.0 - 2.5 and the ratio to the intensity values for CPT 99244 ranges from approximately 1.3 - 1.7.

Based on time comparison alone to the reference services the RVW for CPT 95951 would range from 4.18 (1.875 x 2.23) to 6.48 (6 x 1.08). An RVW value of 6.27 based on both time and intensity can be arrived at by multiplying 4.18 (the lowest RVW based only on time) by a conservative intensity factor of 1.5. The AAN is recommending the median RVW value of 6.00 from the survey which represents a very appropriate value when compared to the RVWs associated with the reference services.

RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Your rationale should also describe how the work of performing the service has changed over the past five years. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

(Please See The Following Pages)

RATIONALE - RUC RECOMMENDATION
CPT 95951

DESCRIPTION OF SERVICE

Video monitoring is precisely coordinated with EEG recordings in order to correlate behavioral observations with EEG changes. Video EEG monitoring is critical to the evaluation of intractable epilepsy patients, especially epilepsy surgery candidates and to the differential diagnosis of seizure type. Clinical symptoms such as aphasia, focal clonus, aversive posturing and behavioral changes provide information that is not available with routine EEG (95819), ambulatory EEG (95950) or computerized EEG (95953). The combining of EEG with video provides more localizing information than would the sum of the two studies performed separately. The physician time and skill in recording and interpreting information related to CPT 95951 is considerably greater than most other EEG services.

PHYSICIAN WORK

Time

Patients undergoing a comprehensive epilepsy evaluation are most often monitored continuously. This typically requires an inpatient hospital stay since antiepileptic drugs are reduced or discontinued to increase the likelihood of seizures and decrease the length of hospital stay. Under these conditions, it would be unsafe to allow the patient to leave the hospital for fear of precipitating status epilepticus. Patients must understand the rationale for medication reduction, the risks involved, and the importance of being confined and remaining on camera throughout the procedure despite the loss of personal privacy. In order to explain these details, pre-service time with the patient is significantly more than for other similar EEG procedures such as 8 channel ambulatory EEG or 16 channel ambulatory EEG monitoring as an outpatient.

Analysis and interpretation of each seizure can take 15 to 45 minutes depending on localization, duration and case complexity. All of the seizures must be compared and described in detail. The EEG correlation with clinical activity must be done on a second to second basis. Analysis of EEG data recorded over a 24 hour period, review of video recordings, and synthesis of the EEG data with the video information and other clinical findings and observations takes an average of 60-90 minutes. This estimate does not include the extensive amount of time spent with the patient over the 24-hour period such as interviewing the patient before and after seizures and dealing with agitated and sometimes psychotic patients following seizures. Time spent with the patient is billed and separately reimbursed through hospital visit codes or other evaluation and management procedures.

Intensity

If EEG localization conflicts with reliable clinical signs, extreme caution is needed prior to surgery to prevent the possibility of performing incorrect procedures. It is usually necessary to videotape several of the patient's habitual seizures to assure that they are consistent with the type of seizure usually experienced and to fully understand the details of the seizure semiology. The family is usually shown videotaped seizures to determine if the patient's habitual seizure has been recorded. If the patient experiences multiple types of seizures, it is extremely important to capture this information as it may indicate a different type of surgical intervention.

It is very psychologically stressful and requires a great deal of mental effort and judgment for the physician to use these data to make a determination about the region of the brain to be removed at neurosurgery. In the manner in which this test is usually used, i.e. a medically refractory epilepsy patient seeking neurosurgical cure, this test represents the sole or most important test in determining the site for resection. If done correctly, the patient can be permanently cured of his or her epilepsy. If done incorrectly, this procedure will point the neurosurgeon to the incorrect location for removal, resulting in a patient who continues to have medically refractory epileptic seizures at an even increased rate of severity and frequency, as well as permanent brain damage from removal of normal brain.

Patients receiving incorrect surgery are often left permanently totally disabled, sometimes with inability to remember any new information for the rest of their life. The profound importance of this test, and potential catastrophic effect of error here, weigh heavily on physicians performing this CPT 95951, and this grave stress needs to be taken into account.

Most patients admitted for a comprehensive epilepsy evaluation will have 1-2 seizures per day, but this code must accommodate a broad variation in patients, including some who will have more than 100 seizures per day. Patients may become violent, throw objects, and even run out of the monitoring room during seizures. The physician must always be available to deal with potentially dangerous situations. Psychotic patients are particularly distressing since they have the potential to harm themselves and others.

The greater the number of seizures generally means a larger amount of data and time spent analyzing it. Even on days when there are no seizures recorded, the physician is often analyzing EEG recordings for subclinical seizures spikes, or slowing. While rudimentary computer programs exist for detection of seizures and spikes, the physician must make the final decision regarding a particular event even with the help of computers.

RVW JUSTIFICATION

Survey Results

The American Academy of Neurology has recommended to the RUC a physician work RVW value of 6.00 for CPT 95951-video EEG monitoring, each 24 hours. This value is based on a survey of sixty (60) epilepsy center physicians across the country, who represent the leading neurologists performing this procedure. According to Medical Part B Data, neurology accounts for 93.2% of this procedure and as such is the only specialty appropriate to judge accurately the time and intensity of the work involved.

As described above and supported by our survey data, it is clear that the components of physician time (pre, intra, and post service) and intensity (mental effort and judgment, technical skill and physical effort, and psychological stress) are much greater and more complex for CPT 95951 than for the primary reference services used in this survey, CPT 95819 and 99244. The AAN survey used those reference codes because they are familiar to and frequently used by neurologists who were asked to complete our survey, and they were among the AMA RUC reference services. We were instructed to use the designated neurology services which were on the reference list, and we have followed those instructions.

Our survey showed that the physician work involved in providing CPT 95951 is approximately 5-6 times greater than CPT 95819 (physician work RVW value of 1.08) as well as 2-3 times that of CPT 99244 (physician work RVW value of 2.23).

Comparison to Additional Reference Services

Several CPT codes could have been chosen for comparison in our survey. Other neurodiagnostic CPT codes are more directly relevant for assessing physician work RVW values for CPT 95951. In comparison to CPT 95810, polysomnography (physician work RVW value of 3.53), CPT 95951 is greater in all aspects, i.e. requires more physician time, requires a greater degree of mental effort and judgment, and exacts a much greater amount of psychological stress. For example, polysomnography, if interpreted incorrectly will lead to prescription of incorrect medications or the use of nocturnal sleep aid devices not appropriate for that patient. This may have substantial social implications such as automobile accidents from persistent excessive daytime sleepiness.

On the other hand, CPT 95951 is used to determine which part of a patient's brain to remove in a patient with medically refractory epileptic seizure whose MRI and CT are normal. Procedure 95951 directs the physician to choose which lobe of the brain to remove. If 95951 is interpreted incorrectly, the patient would be sent to surgery to have the wrong part of the brain removed. In that case, the patient would continue to have medically refractory epileptic seizures, plus suffer substantial additional brain damage from inappropriate surgery. The effects of the incorrect surgery cannot be undone. If 95951 is read correctly, the patient can undergo surgery which will cure his or her epileptic seizures permanently. A decision about where to operate is based often solely on the 95951 results, so the intensity and psychological stress of interpreting these correctly is very great.

In comparison to CPT 95958, intracarotid amytal testing (physician work RVW value of 4.25), the work of CPT 95951 is higher in all aspects, i.e. requires more physician time, and a greater degree of mental effort and judgment as well as greater psychological stress. CPT 95958 is a test which can prevent

inappropriate or incorrect surgery from being performed to remove a part of the brain which is necessary for memory. However, it is usually answered in a *yes* versus *no* manner. This is less complex than the decision making needed in CPT 95951 to draw a dotted line on a map of the human brain, indicating which parts of the brain to remove.

In comparison to CPT 95829, electrocorticography (physician work RVW value of 6.21), the two procedures are somewhat similar. They are similar in terms of the time required, mental effort, psychological stress and other factors. Both are similar in that they are procedures in which the physician must evaluate a human brain and make a decision as to which part should be surgically removed, both are generally carried out in patients who have a normal CT or MRI. Both are based on electrophysiological recordings of brain waves, and the need to identify subtle signs indicating which regions ought to be removed. Both require a very great amount of experience and training in order to carry out the procedure.

In comparison to CPT 95950, ambulatory EEG (physician work RVW value of 1.51), the work of CPT 95951 is very substantially greater in time, intensity, mental effort and judgment, and psychological stress. CPT 95950 is for an ambulatory EEG monitor worn by the patient, similar to a cardiac Holter monitor. This small belt pack or purse records 8 channel EEG for 24 hours. It is subsequently reviewed to see whether or not the patient is having seizures including non-convulsive or subclinical seizures such as brief petit mal attacks during school hours. The technique of ambulatory EEG, CPT 95950, resembles Holter in the recording, but uses 8 separate channels of EEG and has no automated microprocessor identification of arrhythmic events. As such, ambulatory EEG requires more work by the physician to review 8-fold more data and to do the screening of the EEG without the advantage of a microprocessor to identify salient events. The goal of 95950 is to find, count, lateralize and subtype seizures occurring during one day. This leads to proper medication therapy. In contrast, video-EEG epilepsy monitoring, CPT 95951, is a substantially different clinical goal. CPT 95951 is meant to exactly localize an epileptic focus for surgical therapy, rather than just identify, count, subtype and lateralize the nature of seizures as is done for CPT 95950. The CPT code book gives a superficially similar description to CPT 95950 and 95951, whereas the clinical community uses them for very different purposes.

Change in Work

As indicated by 87% of the survey respondents, the amount of work for CPT 95951 has substantially increased in the past five years. First, with the advent of medical marketplace forces, the duration of stay on inpatient epilepsy monitoring units has been considerably reduced. The inpatient work that used to be done in 7-30 days is now done in 4-10 days. For an individual patient, the length of stay has been reduced by several-fold. However, the need to obtain a sufficient number of seizures has not changed. As such, clinically the patients are much more abruptly withdrawn from their anti-epileptic medication and sleep deprived, so as to provoke epileptic seizures to occur much more frequently. As a result, instead of capturing one seizure per day, the procedure now captures several seizures per day. The amount of work to review several seizures is several-fold more than the amount of work to review one seizure. therefore, the amount of work has increased.

The second reason the procedure is now more complicated is that more complex, sicker patients are also receiving video-EEG monitoring, compared to five years ago. Some patients have several seizures per hour, so that the entire monitoring can be accomplished in one day instead of several. Patients who have 20-40 brief atonic or partial seizures in one day will require the review of this entire collection of brief partial events individually seizure by seizure. The amount of work to review 20-40 brief partial seizures is immensely more than the work to review the traditional one complex partial seizure, with possible secondary generalization, as was typical of this procedure five years ago.

The third reason 95951 now is more complicated has to do with the available technology. Five years ago it was common to record just 16 channels on most patients, whereas now a much greater number of EEG channels is available technologically. The physician is therefore faced with 32-128 channels of data to review, rather than just 16 in many patients. As such, the procedure has evolved over the past five years to require substantially more physician work, because of medical marketplace forces compressing the time

to capture seizures, the evaluation of sicker patients and a logical expansion of the amount of data stored and reviewed. (The good news is that 70-90% of these surgical epilepsy cases are successfully treated by surgery, including patients with 20-40 brief atonic drop attacks and brief partial seizures per day who can be surgically cured of their catastrophic epilepsy).

SUMMARY

Overall, the RVW value of 6.00 for CPT 95951 represents a true estimate of the actual physician time and intensity involved in performing video-EEG epilepsy monitoring services. A value of 6.00 is determined to be reasonable, both based in comparison to the reference CPT codes on which our survey was necessarily based, as well as in comparison to other neurodiagnostic CPT codes such as 95810, 95829, 95950 and 95958. The procedure has enormous potential for positive value to the patient when it can cure epilepsy permanently, but enormous threat of permanent substantial harm to the patient if done incorrectly. The work has increased over five years due to medical marketplace forces, use in more complex sicker patients and technologically driven expanded data collection. It is of the utmost importance that the complexity and duration of physician work be recognized appropriately in the Resource-Based Relative Value Scale.

Public Comments

06-Jul-95

Code: 95951

1995 RVUs: 3.8

Recommended RVUs: 6.75

Ratio:

Long Descriptor: Monitoring for identification and lateralization of cerebral seizure focus by attached electrodes; combined electroencephalographic (EEG) and video recording and interpretation, each 24 hours

Reference Set (y/n): N Global Period: XXX Frequency: 8,529 Impact: 25161

Source: 7 Year: 93 Public Comment Letter: 313

Reference Services:

CMD Comment:

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Societies Wishing to Survey: AAN

Societies Wishing to Comment: ASIM

Trends Analysis - Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
95951	6.5	2.4	18.6	46.7	88.7	0	0	3.5

Trends Analysis - Frequency:

	QX92	QX94	Chg92_94
95951	3254	9144	67.6

Trends Analysis - Site of Service:

	Pct in 92	Pct in 94	Chg92_94
95951	78	92.1	7.1

Trends Analysis - Specialty Mix:

	Specialty	PCT_94
95951	group practices	4.3
	neurology	93.2

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
95951	300	1	NEUROTIC DISORDERS
	345	20.9	EPILEPSY
	780	3.2	GENERAL SYMPTOMS

Public Comments

06-Jul-95

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
95951							
AAN		XXX	XXX	1.79	3.80	2.12	1.82

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
95951								
AAN	3.80	3.80	1.02	2.09	1.00	1.00	6.75	313

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	Itime	Notett	Imppt
95951								
AAN	XXX	1.79	t	.		56	t	.

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
95951									
AAN	

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	Iwput
95951									
AAN		.		6.75	3.80	nr	3	0.032	

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

RUC RECOMMENDATIONS

Anesthesiology

Comments

During the comment period for the five-year review, the American Society of Anesthesiologists (ASA) submitted the report of a study conducted by Abt Associates covering all the codes for anesthesiology services in CPT. The study was conducted to try to assess the work of anesthesia services in a way that does not rely on the current anesthesia conversion factor. The average times for anesthesia services that were published in the December 8 Federal Register were accepted with no modifications.

Medicare payments for anesthesiology services are based on the ASA Relative Value Guide (RVG). The RVG assigns a base unit to each code. Anesthesiologists then report their time for each procedure, and the time is added to the base units. This sum is then multiplied by the anesthesiology conversion factor. Although the relative values for each service are not based on the Harvard RBRVS study, the Harvard study was used to determine what the anesthesiology conversion factor should be. As with other specialties, Harvard first conducted a survey of anesthesiologists of the work involved in a number of anesthesiology services, two non-anesthesiology procedures (Swan-Ganz catheter and epidural injection of an anesthetic substance), and two visit services. Then, cross-specialty links were selected and the anesthesia services were placed on the common scale with other specialties. HCFA's use of these results produced a 40% reduction in the work RVUs for anesthesiology, which was a 27% reduction in the anesthesia conversion factor.

In its comment, the ASA claims that the Harvard cross-specialty process produced flawed results, and this is the reason for the Abt study. The study involved convening a multidisciplinary panel of 12 physicians. The average anesthesia times for 15 surgical procedures selected for in-depth study were accepted as correct. The panel separated the anesthesia time for each service into five components: prework, induction, procedure, emergence, postwork. The sum of induction, procedure, and emergence are equal to the HCFA supplied intra-service times.

For each component of these reference services, the panel rated the intensity (defined as intrawork per minute, or IWPUT) of the work effort. Four key procedures were selected as the key levels of intensity for use in this comparison:

99204 Office visit, new patient, .027 IWPUT
62279 Injection of anesthetic substance; epidural, lumbar or caudal, continuous, .044 IWPUT
99291 Critical care, 0.061 IWPUT
33405 Replacement, aortic valve, with bypass; with prosthetic valve, .090 IWPUT

The intensity values were then multiplied by the time for each component to produce recommended RVUs on the same scale as other services in the Medicare payment schedule. The 15 studied services represent 45.6% of total Medicare payments for anesthesia services. A regression analysis was done

to extrapolate from the 15 to the other anesthesia services in CPT. Based on the results, the ASA recommends that the work RVUs for all anesthesia services be increased by 40% through an increase of about 27% in the anesthesia conversion factor.

RUC Evaluation

The RUC's evaluation of the ASA comment focused initially on the methodology employed by Abt, particularly the use of assigned intensity levels rather than measures of physician work, through an evaluation by the RUC's Research Subcommittee. The Research Subcommittee was informed that previous efforts to measure intensity had not been successful. They suggested to the ASA that, because many anesthesiologists have experience in other specialties, a study could be conducted of double-boarded anesthesiologists in which physicians could assess the work involved in reference services compared to the work involved in both anesthesia and non-anesthesia services. Such a study could provide a means for validating the approach of assigning intensity levels to the discrete time periods. In addition to its discomfort with assigning intensity levels, in its initial evaluation of the study the RUC also expressed concern about the particular levels of intensity selected, especially the use of the IWPUT of 99204 as the lowest value for any anesthesiology work, which is used for the period when the surgeon is performing the operation. They did note that the regression analysis used to expand the study from the 15 services directly studied to the 250 anesthesiology codes in CPT appeared to work well.

Subsequently, the ASA did conduct a study of double-boarded anesthesiologists. This survey, however, produced even higher RVUs than the panel. The ASA also reconvened the panel to review the survey results and to discuss the levels of intensity assigned to the codes. The panel used the survey results to refine its previous estimates, but did not adopt the survey results as a substitute for its previous approach. The panel also confirmed its view that the intensity levels selected are correct.

The RUC workgroup which evaluated the ASA recommendation asked for a better explanation of the intensity levels selected, particularly the use of 0.027, the IWPUT for evaluation and management services (E/M), as the reference service for that period of time when the surgeon is doing the procedure and the patient is anesthetized. The ASA advisor explained that during this period the anesthesiologist is continuously monitoring the patient, integrating the anesthesia care with what the surgeon is doing, integrating data, making decisions, and doing whatever has to be done for the patient. This was considered by the panel to be equivalent to face-to-face E/M work.

The workgroup concluded, however, and the RUC agreed, that although this period of time clearly involved two of the components of physician work, time and stress due to the risk of harm to the patient, this part of each procedure does not involve the same mental effort and judgement and technical skill and physical effort as an E/M encounter. A suggestion was made that the intensity might be more comparable to postoperative E/M services, at 0.013 per minute, than face-to-face E/M intrawork at 0.027.

This workgroup also analyzed the results of the analysis of the 15 services by calculating: (1) recommended total work RVUs/intraservice time, and (2) recommended total work RVUs/total time. Comparisons were also made by the workgroup and the full RUC between several of the anesthesia services and services on the MPC, as well as between the anesthesia work on the day of a procedure and the surgeon's work on that day.

- The anesthesia work involved in code 32480 [*Removal of lung, other than total pneumonectomy; single lobe (lobectomy)*], 10.90 RVUs recommended for anesthesia] was compared to the surgeon's work for code 66984 [*Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)*], 9.89 RVUs]. The RUC also compared the total anesthesia work for 32480 (10.90 recommended) to the surgeon's intrawork for 32480 (9.58 RVUs).
- Similar comparisons were made between the surgeon's intrawork for code 44140 [*Colectomy, partial; with anastomosis*], 16.97 RVUs, 8.59 intrawork RVUs] and the recommended anesthesia intrawork for 44140, at 4.51 RVUs (5.25 total anesthesia RVUs).
- Similar comparisons were made for codes 44152 [*Colectomy, partial; with rectal mucosectomy, ileoanal anastomosis, with or without loop ileostomy*], 12.69 surgical intrawork, 12.6 anesthesia intrawork], and for the comparison between 58150 [*Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)*], 9.26 surgical intrawork] and the anesthesia work for 59515 [*Cesarean delivery; including postpartum care*], 4.18 anesthesia intrawork and 5.71 total anesthesia work recommended].

Following this review, the ASA made some adjustments to its Phase II recommendations by reducing the IWPUT for the period of time considered to be equivalent to E/M services from 0.027 to 0.025. They also shortened the number of minutes to which the two highest intensity levels were assigned. An exhibit displaying the final ASA-recommended numbers for the 15 studied services is appended to this recommendation.

RUC Recommendation

Based on this review, the RUC did not find the anesthesia study sufficiently compelling to justify changing the work RVUs by increasing the conversion factor and, therefore, recommends that the current values be maintained. The approach used by the ASA to value these services is reasonable. The results of the ASA method showed that dividing the periods into induction, procedure, and emergence and valuing each component based on its IWPUT is a reasonable way to validate anesthesia services and produces results that are comparable to services provided by other specialists. This methodology produced a reasonable rank order for anesthesia services. The RUC is concerned, however, that the specific levels of intensity used in the analysis may be too high.

Ex
Revised Work RVUs For Anesthesia Codes by Component

Anesthesia Code Surgical Code	Description	Measure	Time Periods					TOTAL All periods
			Pre-Anesth	Induc.	Procedure	Emerg.	Post Anesth.	
00142 66984	Anesthesia for procedures on eye; lens surgery (anesthesiologist places block)	Time (minutes)	15	20	44	7	5	81
		Work Per Minute	0.027	0.053	0.025	0.027	0.027	0.032
		Work RVU	0.41	1.06	1.10	0.19	0.14	2.89
00142 66984	Anesthesia for procedures on eye; lens surgery (anesthesiologist does not place block)	Time (minutes)	10	20	44	7	5	86
		Work Per Minute	0.027	0.027	0.025	0.027	0.027	0.028
		Work RVU	0.27	0.54	1.10	0.19	0.14	2.23
00350 35301	Anesthesia for procedures on major vessels of neck; not otherwise specified	Time (minutes)	20	25	140	20	20	225
		Work Per Minute	0.027	0.054	0.044	0.061	0.027	0.044
		Work RVU	0.54	1.36	6.16	1.22	0.54	9.82
00404 19240	Anesthesia for procedures on anterior integumentary system of chest, including subcutaneous tissue; radical or modified	Time (minutes)	13	18	104	10	10	155
		Work Per Minute	0.027	0.036	0.025	0.036	0.027	0.027
		Work RVU	0.34	0.66	2.60	0.36	0.27	4.22
00540 32480	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum; not otherwise specified	Time (minutes)	20	40	140	20	20	240
		Work Per Minute	0.027	0.057	0.044	0.061	0.027	0.045
		Work RVU	0.54	2.27	6.16	1.22	0.54	10.73
00562 33411	Anesthesia for procedures on heart; pericardium, and great vessels of chest; with pump oxygenator	Time (minutes)	20	40	240	30	30	360
		Work Per Minute	0.027	0.040	0.040	0.061	0.027	0.040
		Work RVU	0.54	1.59	9.65	1.83	0.81	14.42
00770 35081	Anesthesia for all procedures on major abdominal blood vessels	Time (minutes)	20	40	210	21	20	311
		Work Per Minute	0.027	0.044	0.043	0.044	0.027	0.041
		Work RVU	0.54	1.76	9.12	0.92	0.54	12.88
00830 49505	Anesthesia for hernia repairs in lower abdomen; not otherwise specified	Time (minutes)	10	20	56	10	10	106
		Work Per Minute	0.027	0.036	0.025	0.027	0.027	0.028
		Work RVU	0.27	0.71	1.40	0.27	0.27	2.92
00840 44140	Anesthesia for intraperitoneal procedures in, lower abdomen including laparoscopy; not otherwise specified	Time (minutes)	16	18	121	15	12	182
		Work Per Minute	0.027	0.036	0.025	0.036	0.027	0.028
		Work RVU	0.43	0.66	3.03	0.58	0.32	5.01
00850 59515	Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; cesarean section	Time (minutes)	10	30	52	15	10	117
		Work Per Minute	0.03	0.06	0.04	0.03	0.03	0.040
		Work RVU	0.30	1.78	1.95	0.41	0.27	4.71
00910 52336	Anesthesia for transurethral procedures (including urethrocytoscopy) not otherwise specified	Time (minutes)	10	15	38	10	10	83
		Work Per Minute	0.027	0.038	0.025	0.027	0.027	0.028
		Work RVU	0.27	0.58	0.95	0.27	0.27	2.34
00914 52601	Anesthesia for transurethral procedures (including urethrocytoscopy); TUR	Time (minutes)	15	20	62	13	10	120
		Work Per Minute	0.027	0.044	0.025	0.027	0.027	0.029
		Work RVU	0.41	0.88	1.55	0.35	0.27	3.46
01210 27244	Anesthesia for open procedures involving hip joint; not otherwise specified	Time (minutes)	20	38	80	10	15	163
		Work Per Minute	0.030	0.040	0.044	0.027	0.027	0.039
		Work RVU	0.60	1.54	3.52	0.27	0.41	6.33
01214 27130	Anesthesia for open procedures involving hip joint; total hip replacement	Time (minutes)	20	47	120	20	15	222
		Work Per Minute	0.027	0.032	0.035	0.036	0.027	0.033
		Work RVU	0.54	1.52	4.14	0.71	0.41	7.32
01270 35556	Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified	Time (minutes)	20	35	180	15	15	265
		Work Per Minute	0.027	0.042	0.025	0.027	0.027	0.028
		Work RVU	0.54	1.48	4.50	0.41	0.41	7.31
01382 29881	Anesthesia for arthroscopic procedures of knee joint	Time (minutes)	10	28	55	10	10	111
		Work Per Minute	0.027	0.034	0.025	0.036	0.027	0.028
		Work RVU	0.27	0.87	1.38	0.36	0.27	3.14

AMA/Specialty Society RVS Update Committee
RBRVS Five-Year Review Recommendations

19

Special List of Potentially Overvalued Services

When the RUC Subcommittee on the Five-Year Review was developing its initial proposals for how services should be identified for inclusion in the review, it determined that structured analyses of available data on work per unit time and changes in work over time should be conducted to identify potentially overvalued services. Those services identified as outliers through this type of analysis would be considered good candidates for review. Although the same approach could have been used to identify potentially undervalued services, it seemed likely that the specialty societies would identify the most important undervalued services during the public comment period. Several groups, including the Physician Payment Review Commission, underscored the need to focus considerable attention on identifying potentially overvalued services. It was difficult for the RUC to select the best method to identify all the misvalued services that should be included in the review. Many undervalued services and some overvalued services were identified in the public comments, and the CMDs identified a large number of potentially overvalued services. The RUC also conducted its own analyses, described below, and by June, the RUC had made a comprehensive search for additional potentially overvalued codes, using all the possible screens and individual codes suggested by the RUC members and others.

An initial analysis of work per unit time and other service characteristics was developed by HCFA staff and provided to the CMDs to assist them in developing misvalued services. Daniel Dunn, PhD, who served as a consultant to the RUC throughout the five-year review, noted several problems in the way the analysis was conducted, however, which produced some irrational results, such as negative work per unit time for some services. In addition, the analysis did not encompass potential changes in work over time, and, from the rationales provided for their comments, it appeared that the CMDs relied more on their own impressions about the proper relationships between codes than on the analysis provided to them by HCFA. To ensure that the five-year review included all the potentially overvalued services that it should include, the RUC subcommittee had several additional analyses conducted and used the results to identify additional potentially overvalued services:

1. HCFA provided the AMA with the most current available data on Medicare utilization, site-of-service, and provider of service. Using these data, the AMA identified trends in service frequency and site from 1989-1994 and from 1992-1994. The RUC took the view that a combination of a high rate of increase in annual frequency combined with a shift from inpatient to outpatient site-of-service could be an indicator that services were becoming more commonly or routinely provided, and that the work involved each time the service was done may be less than the current RVUs imply.
2. Dr. Dunn did an alternative analysis of intrawork per unit of time (IWPUT) for each service which corrected for the problems he had identified in the HCFA analysis. Codes were divided into clinical groupings and then the mean IWPUT for the group was identified. All the codes in the group were then assessed according to their level of deviation from the mean. Potentially overvalued codes were indicated as either being above the mean or being 3, 4, or 5 standard deviations above the mean.
3. Individual members of the RUC had reviewed both data on the codes on the Multispecialty Points of Comparison (MPC) and the initial results of the AMA analysis of trends in Medicare claims. They suggested about 80 codes that might warrant closer scrutiny. Dr. Dunn reviewed these codes to determine how the final Harvard work values compared to the current RVUs for the codes. If the final Harvard value was more than 20% below the current RVUs, the code was considered potentially overvalued. (Dr. Dunn also analyzed all codes comparing the final Harvard

RVUs to the current RVUs and identified those for which the Harvard RVUs were 20% below the Medicare RVUs, but the RUC believed there were too many possible explanations for these differences and did not make further use of the results except as described.)

The RUC decided to include the following categories of codes in the five-year review based on these analyses:

1. From the "Trends" analysis: from 1992 through 1994, the frequency of Medicare claims submitted for the service increased by an average of more than 25% per year, the percentage of times the service was provided in an inpatient setting decreased by more than 5% per year, and there were more than 1,000 Medicare claims for the service in 1992 and 1994.
2. From the "Outlier IWPUT" analysis: services identified as 3 or more standard deviations above the mean in the analysis of intraservice work per unit of intraservice time for clinical groups.
3. From the "RUC + Harvard" analysis: services identified for review by one or more members of the RUC or by the Five-Year Review Subcommittee for which the final Harvard RVUs are significantly lower than the 1995 Medicare RVUs.

After eliminating from these three categories those codes that were already included in the five-year review because of the comment process, the RUC asked HCFA if 33 of these potentially overvalued codes could be included in the five-year review. Since the codes were not identified until June 1995, the RUC also asked if it could take more time if necessary to complete review of these codes. HCFA agreed to add the codes and to allow more time if necessary to review them.

The RUC disseminated the list to all the specialty societies on the Advisory Committee and, as with the codes identified through the comment process, asked them to indicate whether they wished to be involved in developing the primary recommendation to the RUC for each code. Those specialties that responded affirmatively were asked to take one of the following four actions:

1. recommend a lower relative value for the code;
2. demonstrate, if the code was identified by Dr. Dunn's analysis of the Harvard data, that it is appropriate that the service have a higher IWPUT than other clinically related codes or that the current Medicare RVUs are more appropriate than the Harvard RVUs;
3. demonstrate, if the code was identified by the AMA trends analysis, that the service work has not decreased over time; or
4. show why the code was identified for review in error.

For 11 of the 33 codes, the specialties recommended that the RVUs be reduced, and the RUC concurs with these recommendations. Five of them were found to have been identified in error because of problems in the BMAD data or because previous coding changes were responsible for the

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KEY: 1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality

trend changes. For an additional 12 services, the RUC has reviewed the services and recommends that the current RVUs be maintained. Review of five services has been deferred until the February 1996 RUC meeting. The primary review of most of these services was done by the full RUC, not by one of the workgroups.

The table below shows the codes included in the list, their 1995 RVUs, the RUC-recommended RVUs, the basis for including the code in the list (e.g., "Trends"), and the rationale for the RUC's recommendation. Attachments provide data on the codes from the AMA's and Dr. Dunn's analysis, and any explanatory material provided in writing by the specialty societies.

Code	Descriptor	1995 RVUs	Recommended RVUs	Reason for Review	RUC Rationale	Key
17304	Chemosurgery (Mohs' micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation; first stage, fresh tissue technique, up to 5 specimens	7.60	7.60	Outlier IWPUT	The RUC accepted the AAD explanation that the RVUs for code 17304 were appropriately increased by a HCFA refinement panel for the 1993 RBRVS. The information provided to the refinement panel and the RUC explain the difference between the IWPUT of the Medicare RVUs and the original Harvard RVUs. The RUC recommends the current RVUs be maintained.	2
21015	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp	4.94	4.94	Trends	The RUC accepted the AAO-HNS explanation that code 21015 is still appropriately valued, particularly in comparison to codes 30520 [<i>Nasal septoplasty</i> , 5.55 RVUs], 31030 [<i>Caldwell-Luc</i> , 5.60 RVUs], and 42440 [<i>Excision of submaxillary gland</i> , 6.61 RVUs].	2

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KEY: 1 = Adopt specialty/CMD recommended increase; 2 = Maintain current RVU; 3 = Adopt specialty/CMD recommended decrease; 4 = Adopt increased RVU, but lower than specialty recommended; 5 = Adopt decreased RVU to maintain neutrality

Code	Descriptor	1995 RVUs	Recommended RVUs	Reason for Review	RUC Rationale	Key
25065	Biopsy, soft tissue of forearm and/or wrist; superficial	2.39	1.94	RUC + Harvard	The RUC accepted the reductions in the RVUs for these services which were recommended by the AAOS. Several reasons were provided to justify the decreases. A few of the codes had been initially valued as if they had a 90-day global period, but the global period was subsequently reduced to 10 days. For others, the AAOS reviewed the available data from the Harvard study in detail, as well as its own estimates of pre-, intra-, and postoperative time and work, and concluded that the current Medicare RVUs are incorrect.	3
26992	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), pelvis and/or hip joint	13.97	12.30	Outlier IWPUT		3
27001	Tenotomy, adductor of hip, subcutaneous, open	7.70	6.50	Outlier IWPUT		3
27006	Tenotomy, abductors of hip, open (separate procedure)	9.50	9.00	RUC + Harvard		3
27040	Biopsy, soft tissue of pelvis and hip area; superficial	3.26	2.71	RUC + Harvard		3
27090	Removal of hip prosthesis; (separate procedure)	12.00	10.34	Outlier IWPUT		3
27265	Closed treatment of post hip arthroplasty dislocation; without anesthesia	5.58	4.74	Outlier IWPUT		3
27266	Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia	7.73	6.96	Outlier IWPUT		3
27323	Biopsy, soft tissue of thigh or knee area; superficial	2.67	2.23	RUC + Harvard		3

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Code	Descriptor	1995 RVUs	Recommended RVUs	Reason for Review	RUC Rationale	Key
27550	Closed treatment of knee dislocation; without anesthesia	5.53	5.53	Outlier IWPUP	The RUC accepted the explanation provided by the AAOS that the higher IWPUP of code 27550 is justified in comparison to other dislocations because the service involves limb threatening emergencies, with amputation as a sequelae reported in up to 35% of cases. The AAOS noted that the clinical grouping used to identify this code was "treatment of closed fractures and dislocations in an office," whereas this service is generally provided in either an inpatient hospital setting or in the emergency room.	2
28010	Tenotomy, subcutaneous, toe; single	2.97	Defer	Outlier IWPUP	Deferred until the February 1996 RUC meeting.	NA
31520	Laryngoscopy direct, with or without tracheoscopy; diagnostic, newborn	2.56	2.56	Outlier IWPUP	The RUC accepted the explanation provided by the AAO-HNS that code 31520 is appropriately high in IWPUP, particularly because it involves life-threatening airway obstruction in newborns which may be further precipitated by the procedure, and is, therefore, significantly more intense per minute than other codes which were included in the same clinical grouping, such as diagnostic colonoscopy, proctosigmoidoscopy, and diagnostic esophagoscopy.	2
33970	Insertion of intra-aortic balloon assist device through the femoral artery, open approach	8.05	Defer	Outlier IWPUP	Deferred until the February 1996 RUC meeting.	NA
36010	Introduction of catheter, superior or inferior vena cava	2.43	2.43	RUC + Harvard	The RUC accepted the SCVIR explanation of the work involved in this service and concluded that the current RVUs are appropriate.	2

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Code	Descriptor	1995 RVUs	Recommended RVUs	Reason for Review	RUC Rationale	Key
36821	Arteriovenous anastomosis, direct, any site (eg, Cimino type) (separate procedure)	8.39	8.39	Trends	The RVUs for code 36821 were already reduced in 1993 as a result of the deletion of code 36820. Code 36821 is now being used to describe procedures previously reported as either 36820 or 36821, which explains the increase in claims in 1994. The RUC agreed with the SVS that no further reduction is warranted.	2
37201	Transcatheter therapy, infusion for thrombolysis other than coronary	7.25	7.25	Trends	The RUC agreed with the SCVIR that the frequency of claims for this code is growing because thrombolytic infusion is proving to be an effective therapy for thrombosed arteries and grafts, allowing physicians to save patient limbs. The service is still a relatively new technology and the RUC believes it is currently appropriately valued.	2
41010	Incision of lingual frenum (frenotomy)	1.19	1.01	Outlier IWPUT	The RUC accepted the recommendation from AAO-HNS that code 41010 be valued at 60% of the work of code 41115 [<i>Excision of lingual frenum (frenectomy)</i>].	3
49605	Repair of large omphalocele or gastroschisis; with or without prosthesis	21.92	21.92	Outlier IWPUT	The RUC accepted the explanation provided by the APSA that the higher IWPUT is justified for these two services provided to neonates, particularly due to the high level of clinical judgement required to prevent patient demise or severe morbidity. The pathophysiologic sequelae are the results of the absence of the hollow and solid viscera within the abdomen during fetal life as well as the impact of associated anomalies. The two procedures are described as among the most difficult to teach to postgraduate trainees.	2
49606	Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure, in operating room	17.93	17.93	Outlier IWPUT		2

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Code	Descriptor	1995 RVUs	Recommended RVUs	Reason for Review	RUC Rationale	Key
62275	Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; epidural, cervical or thoracic, single	1.79	1.79	Trends	The RUC accepted the argument made by the ASA that the increasing use of this code is due to improved recognition of the value of thoracic and cervical epidurals in treating pain and increased use of nerve blocks in the treatment of thoracic and cervical back pain and radiculopathy, but that the service work has not decreased, particularly relative to reference procedures including 62289 and 62298 [<i>Epidural injection, non-anesthetic, lumbar and thoracic</i> , 1.64 and 2.20 RVUs].	2
64623	Destruction by neurolytic agent; paravertebral facet joint nerve, lumbar, each additional level	0.99	0.99	Trends	The RUC accepted the argument made by the ASA that the increasing use of code 64623 is due to improved recognition of facet joint dysfunction in the etiology of the mechanical low back syndrome and availability of C-arm fluoroscopy. The RUC also agreed that the service is appropriately valued since it involves about one third more work than code 64622 [<i>Destruction by neurolytic agent; paravertebral facet joint nerve, lumbar, single level</i> , 2.95 RVUs].	2

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Code	Descriptor	1995 RVUs	Recommended RVUs	Reason for Review	RUC Rationale	Key
67210	Destruction of localized lesion of retina (eg, maculopathy, choroidopathy, small tumors), one or more sessions; photocoagulation (laser or xenon arc)	9.48	Defer	Outlier IWP/UT	<p>Like code 17304 (above), the RVUs for this service were increased by a HCFA refinement panel for the 1993 RBRVS to reflect the complexity of the service and the frequency of surgical retreatments provided <u>during</u> the 90-day global period. These retreatments are done during the postservice period, so they are not reflected in the analysis of IWP/UT. In addition, the IWP/UT is appropriately high because the procedure subjects every treated patient to an immediate and substantial risk of vision loss or blindness.</p> <p>Another problem in assessing the appropriate RVUs for this code, however, is that survey responses obtained by the AAO reflect a bimodal distribution: the work involved in treatment of acute macular degeneration is greater than the work involved in treating diabetic retinopathy. The RUC recommends, therefore, that the code be referred to the CPT Editorial Panel for review prior to further consideration by the RUC.</p>	NA
74360	Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation	0.54	0.54	Trends	The RUC accepted the ACR's explanation that code 74360 has increased in frequency because balloon dilation represents an improvement in medical practice and because its use has expanded beyond the esophagus to other areas of the body, such as the small bowel, colon, and duodenum. The work involved in the service has not decreased, and 74360 shares many of the same elements as angioplasty [see code 75962, 0.54 RVUs], including placement of guidewires, fluoroscopy, supervising staff, interpretation, and a written report.	2

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Code	Descriptor	1995 RVUs	Recommended RVUs	Reason for Review	RUC Rationale	Key
77420	Weekly radiation therapy management; simple	1.61	Defer	RUC + Harvard	Due to methodological flaws in the initial survey of these radiation therapy codes, the RUC agreed with the ACR to defer review until the February 1996 RUC meeting.	NA
77425	Weekly radiation therapy management; intermediate	2.44		RUC + Harvard		
77430	Weekly radiation therapy management; complex	3.60		RUC + Harvard		
77761	Intracavitary radioelement application; simple	3.56	3.56	Trends	The ACR suggested and further review of the BMAD data by the AMA confirmed that code 77761 was identified for review in error. Frequency of claims by radiologists for the service <u>decreased</u> by 3.9% annually. A number of <u>anesthesiology</u> claims for the service were reported by one carrier (Pennsylvania), which caused the service to appear in the trends analysis. There is no reasonable explanation for the anesthesiology claims.	2
78803	Radiopharmaceutical localization of tumor; tomographic (SPECT)	1.09	1.09	Trends	The RUC agreed with the ACR that the current RVUs for 78803 should be maintained. The frequency of claims has increased because the service has more clinical applications and because new radiopharmaceuticals have been introduced. This increased reliance on the service in treatment planning, however, requires obtaining more tomographic cuts/slices each time the service is done, so the increased frequency has not diminished the physician work involved.	2
93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous	4.33	4.33	Trends	The RUC accepted the explanation provided by the ACC that the recent increase in frequency of claims for these codes is due to the major coding revision that took place for 1994, which means that the codes are being reported differently than they were before. The time and work involved in the services has not been reduced.	2
93526	Combined right heart catheterization and retrograde left heart catheterization	5.99	5.99	Trends		2

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Code	Descriptor	1995 RVUs	Recommended RVUs	Reason for Review	RUC Rationale	Key
94400	Breathing response to CO2 (CO2 response curve)	0.40	0.40	Trends	The ATS suggested and further review of the BMAD data by the AMA confirmed that code 94400 had been identified for review in error. The pulmonologists reported that the service is rarely provided anymore because of the risks associated with the CO2, and in 1994 fewer than 400 claims were submitted by pulmonologists. The vast majority of claims (86% of the 5,864) were submitted by providers coded as "independent physiological labs" in two Los Angeles localities.	2

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**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

ISSUES REFERRED TO THE CPT EDITORIAL PANEL

For CPT 1997, the AMA placed a moratorium on specialty requests for coding changes in order to prevent a large number of new codes from being implemented at the same time as the changes in the RBRVS due to the five-year review. The only coding change requests being considered are those for new technologies that cannot currently be reported with other codes in CPT and those for codes that are not on the RBRVS (e.g., clinical laboratory services). The RUC and the CPT Editorial Panel had also anticipated, however, that a small percentage of the issues included in the five-year review would require review by CPT before they could be considered by the RUC, because it appeared likely that some comments on misvalued codes would actually be due to the codes' nomenclature.

After reviewing the comments referred for inclusion in the five-year review, the RUC identified 25 issues that it recommends be considered by CPT prior to further review by the RUC. The specialty societies submitting the comments have been informed of this decision, and have been asked to submit proposals to CPT in time for any coding changes to be reviewed by the RUC and reflected in CPT 1997 and the 1997 RBRVS, simultaneous with the other changes due to the five-year review. These issues are discussed in the table which follows.

In addition to those requiring further review by CPT, four issues were addressed in five-year review comments which were already addressed by the CPT Editorial Panel and the RUC as part of the updates for CPT 1996. These issues are also discussed in the table.

The American Academy of Pediatrics (AAP) submitted a public comment requesting that 480 CPT codes each be divided into several codes for different age categories, and that about 20 new codes be added for pediatric services that are not currently described in CPT. To address these issues, a Pediatrics Committee was formed comprised of RUC members and two members of the CPT Editorial Panel. This committee has made several recommendations to the AAP about how to best confront the issues raised in its comments. Proposals addressing these recommendations will also be submitted to the CPT Editorial Panel in time for them to be considered for CPT 1997.

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
11043	Debridement; skin, subcutaneous tissue, and muscle	1.83	AAOS	A CMD commented that 11040 involves substantially more time than 11043 and recommends that the RVU be 2.60.	The AAOS survey for these services resulted in significant differences with Harvard data. It appears that the services that orthopaedic surgeons are performing while utilizing these codes is different than other providers who also use these codes. The RUC recommends that the CPT Editorial Panel review this issue and determine if separate codes are appropriate.
11044	Debridement; skin, subcutaneous tissue, muscle, and bone	2.28	AAOS/CMD		
11710	Debridement of nails, electric grinder; five or less	0.32	CMD	A CMD commented that grinding requires less time than manual scraping and the relationship to 11700 <i>Debridement of nails, manual; five or less</i> (0.32) should be the same as 11711 <i>Debridement of nails, electric grinder; each additional, five or less</i> (0.20) to 11701 <i>Debridement of nails, manual; each additional, five or less</i> (0.23)	The terminology in these codes is confusion (i.e., five or less and each additional, five or less). CPT should consider collapsing these codes and not specify the method of debridement.
11711	Debridement of nails, electric grinder; each additional, five or less	0.20	APMA	11711 should be valued equal to 11700 to be consistent with the relationship between 11700 and 11710.	
11971	Removal of tissue expander(s) without insertion of prosthesis	1.51	CMD	A CMD commented that this code is roughly two times the difference in intraservice work of 11970 <i>Replacement of tissue expander with permanent prosthesis</i> (6.65), plus follow-up visits in the global period and recommended an RVU of 3.60.	The CPT code needs to be clarified. A number of different specialties are using the code, some inappropriately. The Editorial Panel needs to address how the repair should be reported.

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
13300	Repair, unusual, complicated, over 7.5 cm, any area	5.11	ASPRS/IND	An individual commented that Code 13300 is undervalued and raised concern regarding potential abuse of this code. ASPRS also commented that these codes are extremely variable and indistinct.	CPT should clarify these codes to minimize potential abuse.
14300	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area	10.76	ASPRS		
15000	Excisional preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissue), scar, or other lesion prior to repair with free skin graft (list as separate service in addition to skin graft)	1.85	ASPRS	ASPRS expressed concern that many varying sizes of wounds fall under this one code and that the preparation of this is externally inconsistent.	All these codes are highly variable in time, intensity, work and morbidity. These codes are used in conjunction with other codes. The ASPRS requested, and the RUC agrees, that CPT review the issue of add-on codes.
15101	Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits); each additional 100 sq cm, or each one percent of body area of infants and children, or part thereof	1.72	ASPRS	The ASPRS commented that these "add on" codes, for each additional 100 sq cm of split graft or 20 sq cm of full thickness graft, were undervalued in terms of time and intensity and recommended that they should be increased to reflect one third of the RVU of the primary procedure.	
15121	Split graft, face, eyelids, mouth, neck, ears, orbits, genitalia, and/or multiple digits; each additional 100 sq cm, or each one percent of body area of infants and children, or part thereof	2.67	ASPRS		
15201	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm	1.32	ASPRS		

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
15221	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm	1.19	ASPRS	The ASPRS commented that these "add on" codes, for each additional 100 sq cm of split graft or 20 sq cm of full thickness graft, were undervalued in terms of time and intensity and recommended that they should be increased to reflect one third of the RVU of the primary procedure.	All these codes are highly variable in time, intensity, work and morbidity. These codes are used in conjunction with other codes. The ASPRS requested, and the RUC agrees, that CPT review the issue of add-on codes.
15241	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm	1.86	ASPRS		
15261	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm	2.23	ASPRS		
15755	Free flap (microvascular transfer)	28.33	ASPRS	This service is undervalued in comparison to microvascular flap procedures, specifically, 20970 <i>Free osteocutaneous flap with microvascular anastomosis; iliac crest</i> (41.22).	The current descriptor describes a variety of procedures and needs to be clarified.
22151	Reconstruction of spine with prefabricated prosthetic replacement following resection of one or more vertebral bodies; thoracic	22.15	AANS	AANS and AAOS submitted comments, based on their earlier studies, that a number of the spinal procedures appear to be misvalued.	These codes were recently revised for <u>CPT 1996</u> . The RUC submitted RVU recommendations for these services to HCFA in May 1995.
22210	Osteotomy of spine, posterior approach, single segment; cervical	22.51	AANS		

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
22315	Closed treatment of vertebral fracture and/or dislocation requiring casting or bracing, with or without anesthesia, by manipulation or traction, each	8.36	AANS	AANS and AAOS submitted comments, based on their earlier studies, that a number of the spinal procedures appear to be misvalued.	These codes were recently revised for <u>CPT 1996</u> . The RUC submitted RVU recommendations for these services to HCFA in May 1995.
22327	Open treatment of vertebral fracture and/or dislocation; thoracic, each	17.56	AAOS		
22554	Arthrodesis, anterior interbody technique; cervical below C2, with bone graft	18.14	AANS/AAOS		
22558	Arthrodesis, anterior interbody technique; lumbar with bone graft	22.12	AAOS		
22610	Arthrodesis, posterior or posterolateral technique, with local bone or bone allograft and/or internal fixation; thoracic	15.11	AANS		
22612	Arthrodesis, posterior or posterolateral technique, with local bone or bone allograft and/or internal fixation; lumbar	22.25	AANS/AAOS		
22800	Arthrodesis, posterior, for spinal deformity, with or without cast, with bone graft; 6 or less vertebrae	16.92	AANS		

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
22802	Arthrodesis, posterior, for spinal deformity, with or without cast, with bone graft; 7 or more vertebrae	31.31	AAOS	AANS and AAOS submitted comments, based on their earlier studies, that a number of the spinal procedures appear to be misvalued.	These codes were recently revised for <u>CPT 1996</u> . The RUC submitted RVU recommendations for these services to HCFA in May 1995.
22812	Arthrodesis, anterior, for spinal deformity, with or without cast, with bone graft; 8 or more vertebrae	27.20	AANS		
22840	Posterior instrumentation; without segmental fixation (eg, single Harrington rod technique)	12.54	AANS		
22842	Posterior instrumentation; segmental fixation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires)	14.42	AAOS		
22845	Anterior instrumentation	12.48	AANS		
31090	Sinusotomy combined, three or more sinuses	8.65	AAO-HNS	This service involves an open procedure to remove disease in three or more sinuses and is similar to codes 31075 <i>Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type)</i> (work RVU = 8.57) and 31255 <i>Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)</i> (work RVU = 6.96) combined. It appears that code 31090 has been confused with the endoscopic procedures.	This code should be clarified with a change in the CPT descriptor. The code should reflect that the service is an open procedure, unilateral, and specify the three sinuses.

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
42880	Excision nasopharyngeal lesion (eg, fibroma)	6.01	AAO-HNS	AAO-HNS believes the current CPT descriptor may be misleading with the example fibroma in the nomenclature. This service is almost always performed for juvenile nasal pharyngeal angiofibroma.	The RUC recommends that the CPT Editorial Panel review this issue and consider changing the example for this code to juvenile nasal pharyngeal angiofibroma to reflect the actual typical patient.
46900	Destruction of lesion(s) anus (eg, condyloma, papilloma, mulluscum contagiosum, herpetic vesicle), simple; chemical	1.81	CMD	The CMDs commented that code 46900 for destruction of anal lesion is overvalued because it involves the simple application of podophyllin to an anal or perianal lesion.	Colon and rectal surgeons report code 46900 when using anoscopy to treat lesions extending past the innersphincteric groove cephalad through the dentate line into the anal canal. There is also a follow-up appointment within the 10-day global period to evaluate the anoderm and repeat the anoscopy. Claims data indicate that colon and rectal and general surgeons provide 58% of these services. Dermatologists provide 17% of the services, however, and the RUC concluded that the service may then involve simple application of podophyllin to an anal or perianal lesion as described in the CMD comment. The RUC recommends that this issue be referred to CPT to consider revising the terminology to specify that the service involves treatment through anoscopy and/or add a new code for the more superficial procedure.

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
49020	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess, transabdominal	9.06	ACS	ACS identified this code as misvalued through a study conducted by Abt Associates Inc.	It was clear from the Medicare claims data that the deletion of code 75990 for percutaneous drainage in 1992 has greatly affected the use of code 49020 for drainage of peritoneal abscess. Only the most complex patients with extensive nonlocalized peritonitis require surgical drainage rather than the percutaneous drainage done by interventional radiologists. Medicare data show that 49% of claims for 49020 are submitted by radiologists and 40% by general surgeons. The RUC recommends that this issue be referred to CPT to consider establishing a separate code for percutaneous drainage so that surgical drainage can be appropriately described and valued.
52340	Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic mucosal folds)	7.76	CMD	A CMD commented that the RVU should be reduced to 5.44 as this service is similar to 52277 <i>Cystourethroscopy, with resection of external sphincter (sphincterotomy)</i> (CMD recommended reduction to 3.44) with 2.00 RVUs are added for the global period.	The AUA presented an argument that 52340 is for pediatric patients who are more complex and difficult; miss-billing occurs with 52500 <i>Transurethral resection of bladder neck (separate procedure)</i> (7.82) because identical language is used and 52340 does not specify congenital cases Agrees that descriptors of 52340 and 52500 are essentially the same. As a result, 52340 should be referred to CPT for clarification of congenital cases and 52500 should remain unchanged.

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
53600	Dilation of urethral stricture by passage of sound or urethral dilator, male; initial	1.21	AUA	AUA commented that these services are undervalued in comparison to 93503 <i>Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes (rvu = 2.43) and 51010 Aspiration of bladder; with insertion of supra-pubic catheter (rvu = 2.54).</i>	RUC recommends that these services are essentially the same and should be collapsed into one code.
53620	Dilation of urethral stricture by passage of filiform and follower, male; initial	1.62	AUA		
53640	Passage of filiform and follower for acute vesical retention, male	1.59	AUA		
54100	Biopsy of penis; cutaneous (separate procedure)	1.90	CMD	CMD recommended a decrease to 0.86 and compared this service to 11100 <i>Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion (rvu = 0.81) and 56605 Biopsy of vulva or perineum (separate procedure); one lesion (rvu = 0.86).</i>	The RUC recommends that CPT review the biopsy codes and determine if site specific codes are necessary.
56300	Laparoscopy, diagnostic (separate procedure)	3.58	ACOG	Code 56300 is the same procedure as 56360 <i>Peritoneoscopy; without biopsy (rvu = 4.04)</i> and should be assigned the same work RVU.	These two procedures are almost identical and ACOG has attempted in the past to have the CPT panel collapse the two codes. The RUC recommends that these codes be collapsed into one code.
56305	Laparoscopy, surgical; with biopsy of peritoneal surface(s); single or multiple	3.80	ACOG	Code 56305 is the same procedure as 56361 <i>Peritoneoscopy; with biopsy (rvu = 4.32)</i> and should be assigned the same work RVU.	

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
65105	Enucleation of eye; with implant, muscles attached to implant	7.82	AAO	This code requires similar work as 67107 <i>Repair of retinal detachment, one or more sessions; scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant, may include procedures 67101, 67105 (rvu = 13.99).</i>	This code was recently revised for <u>CPT 1996</u> . The RUC submitted an RVU recommendation for this services to HCFA in May 1995.
67210	Destruction of localized lesion of retina (eg, maculopathy, choroidopathy, small tumor(s), one or more sessions; photocoagulation (laser or xenon arc)	9.48	Outlier IWPUP	This code was identified by the RUC as having an outlier IWPUP.	The IWPUP analysis and the original HCFA value failed to take into account the re-treatments and the fact that these re-treatments are bundled into the 90 day global period and cannot be billed separately. There is a bimodal distribution of patients treated within this code. The code currently includes treatment of acute macular degeneration and diabetic retinopathy. A code should be added for treatment of the less complex retinal lesions.
68825	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral	1.53	AAO	AAO commented that the descriptor for the code would be revised to delete the "unilateral or bilateral" terminology. Additionally, the work value should be modified to reflect a pediatric patient.	This code was recently revised for <u>CPT 1997</u> . The RUC will review an RVU recommendation for this service at the February 1996 meeting.
78480	Myocardial perfusion study with ejection fraction (list separately in addition to code for primary procedure) (Use only for codes 78460, 78461, 78464, 78465)	0.62	ACC	ACC has submitted a coding proposal to specify this code as an add-on procedure. If the code is structured as an add-on code, it may need to be re-evaluated.	RUC agrees that this service should be referred to CPT for further review. The code needs to be properly identified as an add-on code.

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with medical diagnostic evaluation; initial	0.58	AAO/CMD	A CMD recommends decreases for these codes as there is no evidence that more diligence or attentiveness is required in this drawing than what any physician draws when describing a physical finding.	The RUC is concerned that these codes are currently subject to abuse and submitted often as part of a routine exam. CPT should clarify the nomenclature to minimize miscoding. <i>Note: CPT did revise these codes to delete " with medical diagnostic evaluation" and add "with interpretation and report" for CPT 1996.</i>
92226	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with medical diagnostic evaluation; subsequent	0.50	CMD	The AAO commented that this service is undervalued because the procedure often takes 45 minutes to an hour to completely evaluate the peripheral retina with scleral depression.	
92260	Ophthalmodynamometry	0.50	CMD	A CMD commented that ophthalmodynamometry gives an approximate measurement of the relative pressures in the central retinal arteries and is an indirect means of assessing carotid artery flow on either side. The test consists of exerting pressure on the sclera with a spring plunger while observing with an ophthalmoscope the vessels emerging from the optic disks. This is similar in work to 93875 <i>Noninvasive physiologic studies of extracranial arteries, complete bilateral study (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)</i> (rvu = 0.16).	This service is rarely performed and may be an obsolete procedure. CPT should consider deleting this code.

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
93621	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters; with left atrial recordings from coronary sinus or left atrium, with or without pacing	12.66	ACC	This medical complexity of this service has increased considerable since the code was first developed. Recent medical practice frequently involves a more technically difficult and risky service utilizing a transeptal approach to the left atrium. This code should be split into two distinct codes and appropriately valued.	The RUC agreed to refer this code to CPT based on the changing technology of this procedure. The Editorial Panel should consider splitting the code into several codes.
94150	Vital capacity, total (separate procedure)	0.11	CMD	The CMD commented that the work for this service is the same as 94690 <i>Oxygen uptake, expired gas analysis; rest, indirect (separate procedure)</i> (rvu = 0.07). The technical skill for this procedure is minimal. The time involved is no more than 2-3 minutes. This is a simple test, most commonly done with a hand-held instrument, which provides limited information for interpretation.	The specialty society recommends that 94150 and 94160 be combined into one code. The RUC referred this issue to CPT for deletion of this code.
95872	Needle electromyography, single fiber, any technique	1.50	AAEM	AAEM commented that this service is similar in work to 95864 <i>Needle electromyography, four extremities and related paraspinal areas</i> (rvu = 1.99).	This code were recently revised for <u>CPT 1996</u> . The RUC submitted RVU recommendations for this service to HCFA in May 1995.

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
97250	Myofascial release/soft tissue mobilization, one or more regions	0.45	AOA/ CMD	<p>A CMD commented that the work for myofascial release is no different than the work for regional manipulation. Carrier data also show that 97250 is often billed with E/M codes. If this is national experience, the time built into 97250 for pre- and post-service time should be excluded. The intra-service time of 45 minutes appears high based on anecdotal patient data.</p> <p>The AOA commented that this service appears to be overvalued in comparison to OMT.</p>	The RUC recommends that a workgroup (physical therapists, osteopaths, chiropractors, and any other interested providers) be formed to develop a CPT proposal for manipulation services.
97260	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area	0.19	AOA	The values for these codes represent anomalies with the value for 27250.	
97261	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one or more areas	0.12	AOA		
A2000	Chiropractor manipulation of spine	0.45	ACA/ State	<p>The Colorado Chiropractic Association recommends that this code be valued similar to the mid-level OMT code, 98927.</p> <p>The ACA recommends that either the relative value for this code should be increased to be similar to the OMT codes or all providers should be allowed to report the OMT codes.</p>	The RUC recommends that a workgroup (physical therapists, osteopaths, chiropractors, and any other interested providers) be formed to develop a CPT proposal for manipulation services.

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
97500	Orthotics training (dynamic bracing, splinting), upper and/or lower extremities; initial 30 minutes, each visit	0.31	AOTA	The AOTA commented that these are the only codes in the physical medicine section that need to be reviewed by CPT and surveyed for correct relative values.	The RUC recommends that CPT review these codes to be consistent with the recent changes to the Physical Medicine section.
97501	Orthotics training (dynamic bracing, splinting), upper and/or lower extremities; each additional 15 minutes	0.17	AOTA		
97520	Prosthetic training; initial 30 minutes, each visit	0.37	AOTA		
97521	Prosthetic training; each additional 15 minutes	0.22	AOTA		
99238	Hospital discharge day management	1.06	ASIM/ASCO	ASCO and ASIM both commented that this service is currently undervalued.	This code were recently revised for <u>CPT 1996</u> . The RUC submitted RVU recommendations for this service to HCFA in May 1995.

CPT Code	Descriptor - CPT 1995	95 RVU	COMMENTER	COMMENT	RATIONALE
99301	Nursing facility care	1.07	AMDA	Comments submitted by the American Medical Directors Association on the RVUs for nursing home visits were referred to the RUC by HCFA. Similar to the American Society of Internal Medicine comments on the other evaluation and management services, the comments stated that these patients are sicker, more complex, and that physicians must interact more with family members and coordinate care with other providers.	Six medical specialty societies and the American Nurses Association conducted surveys of the work involved in these codes. The survey process identified significant differences in the way the services are provided by different practitioners, particularly in whether or not a comprehensive geriatric assessment is done. Also, no guidelines on time are provided in CPT for these services, so it was difficult to apply the same extrapolation method from surveyed to nonsurveyed services as had been used in other families of codes.
99302	Nursing facility care	1.67	AMDA		
99303	Nursing facility care	2.29	AMDA		
99311	Nursing facility care, subsequent	0.54	AMDA		
99312	Nursing facility care, subsequent	0.89	AMDA		
99313	Nursing facility care, subsequent	1.19	AMDA		Because of these problems, the RUC recommends that the codes be referred to CPT to consider revising them to address the geriatric assessment and other issues.